

Arcadian Health Plan - Oklahoma

Medical Referral /Authorization

Phone: 800.998.3057

Fax: 877.267.6510

Pharmacy Referral /Authorization

Phone: 800.301.1317

Fax: 866.258.2828

Check One: ROUTINE URGENT EXPEDITED (regular response time would SERIOUSLY jeopardize the life/health of the patient)

Patient Name _____			Patient Phone _____	
Patient Requested Referral Yes No	Member ID Number _____		Sex _____	DOB / /
ICD-9 Code(s): _____		Diagnosis: _____		
MEDICAL AUTHORIZATION REQUEST			PHARMACY EXCEPTION REQUEST	
REFERRED FROM PHYSICIAN			PRESCRIBING PHYSICIAN	
Name _____ Phone _____ Fax _____			Name _____ Address _____ City/State/Zip: _____ Phone _____ Fax _____ Specialty _____ License # _____ DEA# _____	
REFERRED TO PHYSICIAN			MEDICATION	
Name _____ Phone _____ Fax _____ Specialty _____			Name & Strength: Quantity: Direction for Use and Duration: Formulary Medications Tried (w/dates): Justification for Requested Medication or Quantity Exception: Dispensing Pharmacy: <input type="checkbox"/> Retail <input type="checkbox"/> Specialty <input type="checkbox"/> Mail Order <input type="checkbox"/> Long Term Care	
FACILITY				
Name _____ Phone _____ Fax _____ Admit Date/DOS / /				
REQUESTED PROCEDURE(S)				
<input type="checkbox"/> INPT <input type="checkbox"/> INPT REHAB <input type="checkbox"/> OBS <input type="checkbox"/> OUTPT <input type="checkbox"/> SNF <input type="checkbox"/> LTAC Diagnostic/Surgical Procedure / CPT Code(s): DME/Supplies HCPCS Code(s): Home Health: # of Visits PT/OT/ST: # of Visits				
SPECIFIC CLINICAL EXPLANATIONS to support the reason for the request and attach pertinent supporting documentation (If Expedited, please document the serious health consequences the patient would experience if the routine authorization process were followed): 				
Physician Signature: _____			Date: _____	

LIMITATION OF COVERAGE: Coverage for any authorized request is contingent on eligibility at the time of service as well as the limits of the benefit plan