RX PRIOR AUTHORIZATION REQUEST FORM

1. Please send the completed Prior Authorization form and any additional information sheets to OxBridge Health by fax to:
+1 (469) 253-6137 for standard requests
*For expedited requests, please select box below

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested prior authorization(s). Attach additional sheets to this form if necessary. An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

Patient Information			Prescriber Information	
Patient Name			**Prescriber Name**	
Patient Health Plan			**Prescriber Address**	
Patient Member ID #			**Prescriber Phone #**	
Patient Date of Birth			**Prescriber Fax #**	
Patient Phone #			**Prescriber Specialty**	
☐ **Expedite**			**Prescriber DEA #**	
			Prescriber NPI #	

Medication & Medical Information	
Requested Drug(s) & Strength(s)	
Quantity(ies)	
Days Supply	
Expected Duration of Therapy	
Directions	
Diagnosis & Diagnosis Code(s) (ICD-10 Standard Codes)	
Drugs Used Previously to Treat the Same Condition	
Additional Clinical Information or History (Please include any relevant test results and/or medical record notes)	

Attestation: *I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group, or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.*

Signature of Prescriber or Authorized Representative	Date (MM/DD/YYYY)
Print Prescriber or Authorized Representative Name	