SMPA

INFORMATION NEEDED TO PROCESS A PRIOR AUTHORIZATION

(Office use only) ACCOUNT #_____________

PATIENT NAME: ____________________________________ DOB:_____________

ADDRESS:____

CITY /ZIP CODE: ____

List of Current Medications:

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What medications have been tried and failed:

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How long have patients been on them and any side effects?

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Please write in Insurance Information:

Health plan:

ID # :

RX Bin:

RX PCN:

RX Group:

Health net Insurance only: Height _______________Weight_________________