Purchased/Referred Care (PRC) Authorization Request Form

Provider Information
Facility/Clinic Name:
Provider:
Tax ID:
Address:
Point of Contact (Name and Title):
Phone number:
Fax number:

Patient Information
Patient Name:
Date of Birth:
PRC Number:
Requested Dates of Service:

Emergency Visit:

☐ Yes ☐ No

If yes:

- ER Date/Time: ______________________________
- Hospital/Facility Name: ______________________________

Requested Services
Type of Service Requested:
CPT/HCPCS Codes:
Clinical Justification:

Urgent:

☐ Yes ☐ No

If yes, explain: ____

Supporting Documentation (REQUIRED)
☐ *Treatment Plan* ***(REQUIRED)***
☐ *Clinical Notes* ***(REQUIRED)***
☐ *Cost Estimate / Quote* ***(REQUIRED)***
☐ Imaging Reports
☐ Lab Results
☐ ER Records
☐ Other: ____

Was the patient referred to your office by a provider from the Port Gamble S'Klallam Community Health Center?

☐ Yes ☐ No

Has authorization been requested from primary insurance? (PRC is a payer of last resort)

☐ Yes ☐ No ☐ Unknown

Submission Instructions

Fax: 360-925-3984

Please allow 5 business days for response with determination of this request. Response will be faxed to the number you provide.

Questions

Phone: 360-297-9631

Email: prc@pgst.nsn.us

PRC Use Only
Date Request Received:
Alternate Resources: ☐ Yes ☐ No ☐ Unknown
Determination:
Determination made by:
Date of approval/denial sent: