Phone:
Fax:

HAP CareSourc e MI Health Link (Medicare-Medica id Plan)
Provider Prior Authorization Request Form

*indicates required field

Patient Information

Date of Request		Member ID #*					
0 H P E H Last Name*		Member ¶s First Name*					
Date of Birth*		Phone Number					
Member Address		City		State		ZIP	

ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

Place of Service

Office Home Inpatient Hospital Outpatient Hospital Other

Ordering