



Program of All-Inclusive Care for the Elderly (PACE) | www.CenterLightHealthcare.org

# Prior Authorization Request Form

Please fax this form along with any clinical documentation to our Clinical Review Department Fax #: 718-873-2890, making certain this form is completed in its entirety. For questions, please call 1-833-252-2737 (TTY 711), 8AM-8PM, M-F. Please note your request cannot be processed until we receive sufficient clinical documentation.

Time Frame:  Standard - 7 Calendar Days  Urgent - 3 Calendar Days

Date of Request: \_\_\_\_\_ Tentative Date of Service: \_\_\_\_\_

Patient Name: \_\_\_\_\_ CenterLight Member ID: \_\_\_\_\_

Request Sent By: \_\_\_\_\_  PCP  Specialist  DME  Pharmacy

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Are you referring to yourself?  Yes  No Specialty: \_\_\_\_\_

Rendering Provider Name/Facility: \_\_\_\_\_

Rendering Provider Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Rendering Provider: NPI #: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Provider's Medicare #: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

In-Network  Out of Network  Not Known

Place of Service Address: \_\_\_\_\_

Facility Tax ID # (if applicable): \_\_\_\_\_

Diagnosis (ICD 10 Codes): \_\_\_\_\_

Type of Service Requested:  Ambulatory Surgical Procedure  Inpatient Elective Admission  Office  
 Outpatient Facility  Home  Inpatient  Other

Type of Service Requested (Description): \_\_\_\_\_

New or Established Request:  New Request  Established Request

CPT/HCPCS: \_\_\_\_\_ Unit(s)/Visit(s): \_\_\_\_\_ Frequency<sup>†</sup>: \_\_\_\_\_ Duration: \_\_\_\_\_

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\*\*\* PLEASE ATTACH CLINICAL INFORMATION TO SUPPORT THE REVIEW FOR MEDICAL NECESSITY.

\*\*\* Failure to send necessary documentation may result in a denial due to lack of clinical information.

<sup>†</sup> if applicable

CL PACE Prior Authorization Request Form

Last review date: 03102025