



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[†]: _____ Duration: _____

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CPT/HCPCS: _____ Unit(s)/Visit(s): _____ Frequency[†]: _____ Duration: _____

CPT/HCPCS: _____ Unit(s)/Visit(s): _____ Frequency[†]: _____ Duration: _____

*** 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.

[†] if applicable

CL PACE Prior Authorization Request Form

Last updated: 03102025 | Last review date: 06032026