Request for Authorization

Date:

Pages sent:

Person Requesting Authorization:

Provider Name:

Provider mailing address:

Phone #:

Fax #:

Patient name:

DOB:

Member name:

ID:

Case # (if applicable):

DOS:

Services requested to be reviewed (CPT or HCPCS Codes):

Please include number of visits and/or dates you are requesting

Diagnosis Codes:

Mail/Fax request to: **Paragon Benefits, Inc.**
PO BOX 12288, Columbus GA 31917
706-256-6131

Please Note:
•Requests sent without documentation may delay review time
•Completion of Review may take up to 14 business days

www.paragonbenefits.com

ParagOn