PRE-AUTHORIZATION REQUEST

Return this Form to: MPI: Medical Review • Fax: (818) 766-6532
Mail: P.O. Box 1999 • Studio City, CA 91614-0999

Provider Data

Treating Physician or Provider Name		Today's Date	# of Pages
National Provider ID Number	**Tax ID Number**	**Contact Person**	
Address			**Location Code**
City		**State**	**Zip**
Email		**Phone**	**Fax**

Authorization Data

Patient's Name	Patient's Date of Birth	Date the Service is to be Performed
Participant's ID Number	**Participant's Name**	
Number of Units (Visits/Services) Requested	**Anatomic Site (if specific for service)**	

Diagnosis and ICD-10 Codes:

Procedure Requested and CPT / HCPCS Code(s):

Information attached to assist with this review:

- ☐ Letter of medical necessity
- ☐ Clinical quality photos
- ☐ Prescription from treating physician
- ☐ Consultant report with history and physical
- ☐ Office notes
- ☐ MPI questionnaire for all sleep studies, speech therapy, braces, wigs or cranial helmets *(available at www.mpiphp.org)*
- ☐ Additional information requested from Motion Picture Industry Health Plan
- ☐ Other:

Please note that MPI does not require pre-authorization for any medical services or procedures. Our benefits are based on Plan guidelines and medical necessity.