



GENERAL REQUEST FORM MEDICAL REFERRAL AND PRIOR AUTHORIZATION FORM

Specialty / Rendering Provider	
Specialist / Rendering Provider Name (First Last)*	
Provider Specialty*	
Phone #*	Fax #*
Provider NPI:	
Name and Title of person completing form (Please print)	

Facility Information	
Facility Name:	Facility Phone #
Facility NPI:	Facility Fax #*

Patient	
Name (First Last)	
ID #	Sex (at Birth)
Phone #	Client
Birth Date	Age
Is this request to facilitate a hospital discharge?	
Yes	No

Omission of Fax Numbers will prevent the transmission of authorization letters.

Requested Service:			
<input type="checkbox"/> Acute Inpatient Hospitalization	<input type="checkbox"/> Ambulance Services	<input type="checkbox"/> Physical Therapy	
<input type="checkbox"/> Inpatient Substance Abuse Treatment	<input type="checkbox"/> Diagnostic Lab Services	<input type="checkbox"/> Elective Procedure – Inpatient	
<input type="checkbox"/> Specialist Visit	<input type="checkbox"/> Radiology	<input type="checkbox"/> Elective Procedure – Outpatient	
<input type="checkbox"/> Non-Participating Provider Visit	<input type="checkbox"/> Home Health Services	<input type="checkbox"/> Durable Medical Equipment	
<input type="checkbox"/> Emergency Inpatient Admission Notification	<input type="checkbox"/> Other Services:		

Procedure / Service Information:		Procedure Code(s) (CPT/HCPCS):	
Date of Service for Procedure/Visit:	Number of Visits / Procedures Requested:	Diagnosis Code(s):	
If PT, OT, or Speech Therapy, please indicate the number of visits since 1/1/2026: (Benefit Max:30 combined visits per year)		Rationale for Request:	

Please attach supporting documentation (where applicable):		
History & Physical, Labs, Vitals, Imaging, Medical Records, Current Chart Notes, Discharge Planning		
Referring PCP		
PCP Name (First Last)	PCP Phone #	PCP Fax #
PCP NPI:	<i>Authorization requests must be received at least 48 hours prior to the Date of Service Requested.</i>	

Physician / Provider Name (print):	Title:
Physician / Provider Signature:	Date:

Fax PA request AND Supporting Documentation to: SGRX @ 313.217.2040
OR
Submit online at: <https://connect.sgrxhealth.com/healthchoice/providers>