

NAME \_\_\_\_\_

PROVIDER ID \_\_\_\_\_

*I hereby request a copy of the following Prior Approval Roster / Missing Information Letter for my records:*



**PRIOR APPROVAL TYPE (Please Check One)**

Transportation / PCA (must indicate Date of Roster)

Transportation       PCA       Date of Roster \_\_\_\_\_

.....

All other PA Types (must indicate Prior Approval Number)

Pharmacy       DME       Nursing       EyeCare

Physician       Dental       Hearing Aid       Bed Reservation

Routing Sheet required?    YES     NO

**PRIOR APPROVAL NUMBER** \_\_\_\_\_

Please send to:

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

***I give Computer Sciences Corporation authorization to release information regarding my Prior Approval Roster or Missing Information Letter.***

Signature of Provider \_\_\_\_\_

Date \_\_\_\_\_