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.

P.O. Box 12288, Columbus, GA 31917
GNT/GBB Prefix: Fax 706-256-4026
All Others: Fax 706.256.6131

Please Note:

- Requests sent without documentation may delay review time
- Completion of Review may take up to 14 business days