



General Prior Authorization (PA) Intake Form

How to request a Prior Authorization Request Form:

1. **Complete and sign this form.** If the following information is not complete or legible, it may delay the process.
2. **Send the completed form to Flipt via fax at 1-551-298-4368 OR via email at WeCare@fliptrx.com.**

Member Information		Prescriber Information	
Member Name:		Prescriber Name:	
Flipt Member ID:		Prescriber NPI:	
Date of Birth:		Address:	
Address:		City:	
City:		State:	Zip Code:
State:	Zip Code:	Office Phone:	
Phone:		Office Secure Fax:	

Medication Information		
Name:		Strength:
Dosage Form:	Quantity:	Day Supply:
** Please do <u>not</u> include clinical attachments. Flipt will send a PA Request Form if a PA is required **		

Name of Requester: _____

Prescriber Signature (Required): _____ Date: _____

(I attest that the information provided is true and accurate and understand that Flipt may perform a routine audit.)

Upon receipt, Flipt will provide a response within 24 business hours, excluding weekends and holidays.

Confidentiality Notice: The documents and information in this facsimile contain confidential information that may be legally protected under HIPAA. This facsimile is intended only for the use of the individual or entity named above - Flipt. If you are not the intended recipient, you are hereby notified that any unauthorized use, disclosure, copying, distribution, or action taken in reliance on the contents of this information is strictly prohibited by law. If you have received this information in error, please *immediately* notify the sender by phone to confirm the destruction of all documents, and deletion of all information from your system, as applicable.

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