# PRIOR AUTHORIZATION SUPPORT WORKSHEET

*Complete before your appointment and give to the staff handling authorization*

Your organized information helps your provider submit a stronger, more complete request.

*This guide is for informational purposes only and does not constitute legal, medical, or financial advice.*

## Patient & Request Information

| Patient Name | Medication / Procedure Requested | Condition Being Treated | Ordering Provider |
|---|---|---|---|
| | | | |

## Symptoms

**Check all that apply and describe the primary symptom affecting daily life:**

| | | | |
|---|---|---|---|
| ☐ Pain | ☐ Swelling / inflammation | ☐ Mobility limitation | ☐ Urinary symptoms |
| ☐ Respiratory symptoms | ☐ Cardiac / circulation | ☐ Reproductive / hormonal | ☐ Frequent flare-ups |
| ☐ Skin issues | ☐ Sleep disruption | ☐ Digestive issues | ☐ Fatigue |
| ☐ Neurological symptoms | ☐ Weight-related conditions | ☐ Other: _____ | |

**Primary symptom most affecting daily life:**

| Describe briefly |
|---|
| |
| |

## Duration & Severity

| How long has this condition been present? | Current Severity | Functional Impact (check all that apply) |
|---|---|---|
| | | |
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## Prior Treatments Tried — CRITICAL for Step Therapy

*This section is the most important part. Insurance companies routinely deny requests because prior treatment history is missing or undocumented. List every medication, therapy, or intervention already tried for this condition.*

| Treatment / Medication | Approximate Dates | Dose / Duration | Outcome | Provider / Where Treated |
|---|---|---|---|---|
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## Relevant Testing or Outside Records

| Test / Record Type | Approximate Date | Where Performed / Source | Key Finding or Result |
|---|---|---|---|
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## Additional Notes for Provider

| Notes |
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