

Requestor's
 Contact Name

Requestor's
 Contact Number:

Patient Information

*Name: _____

*DOB: _____

*Member ID
 Number: _____

*Member Phone Number: _____

*Service Is: **Elective/Routine** **Expedited/Urgent**

Note: Select Expedited/Urgent to prevent serious deterioration in health or jeopardized ability to regain maximum function.

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 877-403-7162)

***Referral Service Type Requested**

Inpatient	Outpatient	Behavioral Health	Other
<input type="checkbox"/> Surgical Procedures	<input type="checkbox"/> Surgical Procedure	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Skilled Service (SN/PT/OT/SP)
<input type="checkbox"/> Elective Admission	<input type="checkbox"/> PT,OT, ST	<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> DME
<input type="checkbox"/> Elective Observation	<input type="checkbox"/> Imaging	<input type="checkbox"/> Intensive Outpatient (IOP)	<input type="checkbox"/> Dental
<input type="checkbox"/> SNF	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Experimental/Investigational
<input type="checkbox"/> Rehab	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Office Visits	<input type="checkbox"/> Transportation/Transfers
<input type="checkbox"/> LTAC	<input type="checkbox"/> Infusion Therapy		<input type="checkbox"/> _____

Procedure Information

*ICD 10 Diagnosis
 Diagnosis: _____ Description: _____

*CPT/HCPC Code & Description (Include Unit of measure/frequency for supplies):

*Date(s) of Service: _____ Number of Visits: _____

Provider Information

Ordering Provider:

*Name: _____
 *Phone: _____
 *Address: _____

Primary Care Physician

*NPI: _____ TIN: _____
 *Fax: _____

Servicing Provider:

*Name: _____
 *Phone: _____
 *Address: _____

Same as Ordering

*NPI: _____ TIN: _____
 *Fax: _____

Facility:

Name: _____
 *Phone: _____
 *Address: _____

N/A

*NPI: _____ TIN: _____
 *Fax: _____

Request for extension to authorization: _____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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