



Requestor's Contact Name: _____ Requestor's Contact #: _____

Patient Information:

*Name: _____ *DOB: _____

*Patient ID #: _____ *Patient Phone #: _____

*Service Is: Elective / Routine Expedited / Urgent

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

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-855-429-1028)

***Service Type Requested:** Please review plans benefit prior to request

| Inpatient | Outpatient | Other |
|--|--|---|
| <input type="checkbox"/> Emergent Inpatient <input type="checkbox"/> Concurrent Review <input type="checkbox"/> Observation Stay >48 hrs <input type="checkbox"/> Surgical Procedures <input type="checkbox"/> Elective Admission <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Long-Term Acute Care <input type="checkbox"/> Acute Rehab <input type="checkbox"/> Maternity <input type="checkbox"/> NICU Stay <input type="checkbox"/> Transplant <input type="checkbox"/> Bariatric Procedure | <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Chiropractic Services <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Imaging <input type="checkbox"/> Sleep Study (facility based) <input type="checkbox"/> Pain Management <input type="checkbox"/> High Cost Medication >\$1000 (administered in office) <input type="checkbox"/> Bariatric Procedure | <input type="checkbox"/> Home Health /Skilled Services <input type="checkbox"/> Home Infusion/ IVT <input type="checkbox"/> Private Duty Nursing <input type="checkbox"/> DME <input type="checkbox"/> Prosthetics/Orthotics <input type="checkbox"/> Allergy Testing (Ages 4 and under) <input type="checkbox"/> Cosmetic Procedure <input type="checkbox"/> Air Ambulance <input type="checkbox"/> DNA/Genetic Testing <input type="checkbox"/> Other: _____ |

Procedure Information:

*ICD 10 Diagnosis: _____ **Diagnosis Description:** _____

*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies): _____

*Date(s) of Service: _____ # of Units or Visits: _____

Provider Information:

Requesting Provider Is this the patient's Primary Care Physician? Yes No

*Name: _____ *NPI _____ TIN: _____

*Phone: _____ *Fax _____

*Address: _____

Rendering Provider Same as the Requesting Provider

If Requesting and Rendering providers differ, complete section below

*Name: _____ *NPI _____ *TIN: _____

*Phone: _____ *Fax _____

*Address: _____ N/A

Facility

*Name: _____ *NPI _____ *TIN: _____

*Phone: _____ *Fax _____

*Address: _____

Request for extension to existing authorization number:

Always verify eligibility, benefits and prior authorization requirements

PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK (*) AND 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 of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
 Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient and use, distribute, or coping is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.