Authorization Change Request Form

Bright HealthCare™

ALL* fields must be completed in order for this request to be processed. *Incomplete forms will NOT be processed.

Why Use This Form: If you need to change a *facility name, dates of service or number of units/days* on an existing authorization. This form is NOT intended to add codes to an existing authorization. For approval of additional services, please submit a new authorization request.

Fax This Form To: 1-877-438-6832

Requestor Information	
Date of Request:	**Name of Requestor:**
Requestor Contact Information:	
Member Information	
Member Name:	**Member Date of Birth:**
Member ID:	**Authorization Number:**
Authorization Change(s) Being Requested (Check all that apply)	
☐ **Date of Service Change**	
Current Date(s) of Service:	**New Date(s) of Service:**
☐ **Change in number of Units/Days/Visits**	
Current # of Units/Days/Visits:	**New # of Units/Days/Visits:**
☐ **Servicing Provider***	☐ **Servicing Facility***
**Changes to non-participating Providers or Facilities may be subject to denial based on the member's benefit plan.*	
If you are requesting a change to servicing provider or facility, please complete:	
Servicing Provider/Facility Information	**Servicing Provider/Facility Information**
CURRENT Servicing Provider Name:	**NEW Servicing Provider Name:**
CURRENT Servicing Provider NPI:	**NEW Servicing Provider NPI:**
CURRENT Servicing Provider TIN:	**NEW Servicing Provider TIN:**
CURRENT Servicing Facility Name:	**NEW Servicing Facility Name:**
CURRENT Servicing Facility NPI:	**NEW Servicing Facility NPI:**
CURRENT Servicing Facility TIN:	**NEW Servicing Facility TIN:**
☐ **Yes** ☐ **No** **New Servicing Provider/Facility is currently participating in the Bright Health Network.** *If New Servicing Provider/Facility is not currently participating in Bright Health Network, please complete the following:*	
New Provider/Facility Address:	
New Provider/Facility Phone #:	**New Provider/Facility Fax #:**