



Phone: 1-844-926-4522
Fax: 1-888-337-2174

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

Patient Information:

*Name: _____ *DOB: _____
 *Member ID #: _____ *Member Phone #: _____
 *Service Is: New Request Extension to Authorization #
 *Priority Is: Standard (Elective/Routine) Expedited/Urgent - request is to prevent serious determination in health or Jeopardize member's ability to regain maximum function.

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

Inpatient	Outpatient	Behavioral Health	Other
<input type="checkbox"/> Emergent Inpatient	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Cochlear Implants/Hearing Aids
<input type="checkbox"/> Concurrent Review	<input type="checkbox"/> Cosmetic	<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> Dental Anesthesia
<input type="checkbox"/> Surgical Procedures	<input type="checkbox"/> Elective Procedure	<input type="checkbox"/> Intensive Outpatient (IOP)	<input type="checkbox"/> Durable Medical Equipment
<input type="checkbox"/> Elective Admission	<input type="checkbox"/> Advanced Imaging	<input type="checkbox"/> Residential Treatment	<input type="checkbox"/> Diagnostic Service
<input type="checkbox"/> Elective Observation	<input type="checkbox"/> MRI/MRA	<input type="checkbox"/> Substance Abuse Disorder	<input type="checkbox"/> Injectable Medications
<input type="checkbox"/> SNF	<input type="checkbox"/> CT/PET Scan	<input type="checkbox"/> ABA Services	<input type="checkbox"/> Infertility Services
<input type="checkbox"/> Rehab	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> Other:	<input type="checkbox"/> Transportation
<input type="checkbox"/> Maternity	<input type="checkbox"/> Podiatry Services		<input type="checkbox"/> Vision Services
<input type="checkbox"/> Transplant	<input type="checkbox"/> Pain Management		<input type="checkbox"/> Other:
	<input type="checkbox"/> Transplant Workup		

Procedure Information:

*Service Start Date: _____ Service End Date: _____

ICD 10 Diagnosis Code(s)	CPT/HCPCs/Rev Code(s)	Quantity	Requested Type (Units Visits, Days, Hours)	Frequency (Example: 2x/week)

Provider Information:

Ordering Provider Is this the member's Primary Care Physician? Yes No
 *Name: _____ *NPI: _____ TIN: _____
 *Phone: _____ *Fax: _____
 *Address: _____

Servicing Provider Is this the same as the Ordering Provider? Yes No
 *Name _____ *NPI: _____ *TIN: _____
 *Phone _____ *Fax: _____
 *Address _____

Facility
 *Name: _____ *NPI: _____ *TIN: _____
 *Phone _____ *Fax _____
 *Address _____

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

Always verify eligibility, benefits, and prior authorization requirements

For Claim Denial or Prior Authorization Denial, submit an Appeal through Customer Service at 1-844-926-4522

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.

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