Individual & Family Plans / Small Group Plans

Prior Authorization Form

Before submitting this form, verify eligibility, benefits, and prior authorization requirements.

Date of Request |

Fax | 888-319-6479

Phone | 1-844-990-0375

Requestor's Contact Name:	Requestor's Contact #:
*Member Name:	*Member DOB:
*Member ID:	*Member Phone #:
*Member Address:	

Service Is: *(Please Select)*

Standard processing timelines will apply for all non-urgent requests

☐ New Request ☐ Emergent / Urgent - The health of the member may be seriously jeopardized if this request is not reviewed urgently.

☐ Existing Request Please enter authorization #:

Additional Information Submitted: ☐ Clinical information ☐ Discharge information ☐ Reconsideration Request

☐ Other:

Service Type Requested: *(Please review plan benefits prior to request)*

***For existing authorizations, do NOT complete the fields below**

Inpatient Medical	Outpatient Medical	Inpatient Behavioral
☐ Hospice	☐ Ambulatory Surgery	☐ Inpatient Detoxification
☐ Inpatient Medical	☐ Ambulatory Surgery with Obs	☐ Inpatient Hospitalization
☐ Inpatient Rehab	☐ Dental	☐ Residential Treatment
☐ Inpatient Surgery/Procedure	☐ Dialysis	☐ Other
☐ Intraoperative Neuromuscular Monitoring	☐ DME & Supplies	**Outpatient Behavioral**
☐ Labor/Delivery	☐ Home Care	☐ Applied Behavioral Analysis
☐ LTACH	☐ Imaging/Radiology	☐ ETC
☐ NICU	☐ Lab/Diagnostic Testing	☐ Intensive Outpatient Program (IOP)
☐ Skilled Nursing	☐ Drug Administration	☐ Outpatient Treatment
☐ Other	☐ Observation Stay	☐ Partial Hospitalization Program (PHP)
	☐ Office/Clinic Visits	☐ Psychological Testing
	☐ Other Outpatient Medical Service	☐ Transcranial Magnetic Stimulation
	☐ Rehabilitative/Therapy Outpatient	☐ Other
	☐ Other	

☐ **Request is associated with a transplant** ☐ **Request is associated with a clinical trial** NCT#

Diagnosis (ICD -10) Code(s)					
Place of Service *(e.g., Office):*					

CPT/HCPC/ REV Code(s)	Total Quantity	Unit Type *(Units/Day, etc.)*	Number	Frequency *(Hour/Day, etc.)*	Date of Service Start	To Date

Requesting Provider Information *(Cannot be a practice)*

NPI Number:	Requesting Provider Name:	
Tax ID Number:	Phone:	Fax:
Street Address:		

Servicing Provider Information *(Cannot be a practice)*

NPI Number:	Requesting Provider Name:	
Tax ID Number:	Phone:	Fax:
Street Address:		

Servicing Facility/Practice Information

NPI Number:	Requesting Provider Name:	
Tax ID Number:	Phone:	Fax:
Street Address:		

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

Authorization is not a guarantee of claim payment. The payment for these services is subject to using the authorized provider, your plan eligibility at the time of service, and the benefit limitations in your Certificate of Coverage. Incomplete documentation of the TIN for the servicing provider and/or facility/practice may require additional information to be requested in order for payment to claim to be completed.