

Requestor's Contact Name:				Requestor's Contact #:							
Patient Information:											
*Name:				*DOB:							
*Member ID #:				*Member Phone #:							
Work Related Injury?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Motor Vehicle Accident related injury?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
Does the member have other insurance?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, other insurer			
Does the member have Medicare?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes,	<input type="checkbox"/>		
*Service Is:				<input type="checkbox"/>	Elective / Routine	<input type="checkbox"/>	Expedited / Urgent				
Note: Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function. Claim Denial or Prior Authorization Denial: submit Appeal via Appeals Dept. ph 844-865-8033. Members: call 844-480-8528											
*Referral Service Type Requested: Please review plans benefit prior to request											
Inpatient		Outpatient		Behavioral Health		Other					
<input type="checkbox"/> Emergent Inpatient		<input type="checkbox"/> Surgical Procedure		<input type="checkbox"/> Inpatient		<input type="checkbox"/> Home Health /Skilled Services (SN/PT/OT/SP)					
<input type="checkbox"/> Concurrent Review		<input type="checkbox"/> PT, OT, ST		<input type="checkbox"/> Partial Hospitalization		<input type="checkbox"/> Private Duty Nursing (see PDN specific form)					
<input type="checkbox"/> Surgical Procedures		<input type="checkbox"/> Imaging		<input type="checkbox"/> Intensive Outpatient (IOP)		<input type="checkbox"/> DME					
<input type="checkbox"/> Elective Admission		<input type="checkbox"/> Chiropractic		<input type="checkbox"/> Residential Treatment		<input type="checkbox"/> Transportation / Transfers					
<input type="checkbox"/> Elective Observation		<input type="checkbox"/> Acupuncture		<input type="checkbox"/> Chemical Dependency		<input type="checkbox"/> Air Ambulance					
<input type="checkbox"/> SNF		<input type="checkbox"/> Hospice		<input type="checkbox"/> Office Visit		<input type="checkbox"/> Other:					
<input type="checkbox"/> Rehab				<input type="checkbox"/> Other Therapy:							
<input type="checkbox"/> Maternity											
<input type="checkbox"/> NICU											
<input type="checkbox"/> Hospice											
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				Is this the member's Primary Care Provider?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
*Name:				*NPI		TIN:					
*Phone:				*Fax							
*Address:											
Servicing Provider				Is this the same as the Ordering Provider?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If not complete below:											
*Name				*NPI		TIN:					
*Phone				*Fax:							
*Address											
Facility											
*Name:				*NPI		TIN:					
*Phone				*Fax							
*Address											
Request for extension to authorization request:											
ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS. Always verify eligibility, benefits and prior authorization requirements											
<small>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.</small> <small>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.</small>											