



* = Required Information

Requestor's Contact Name: _____

Requestor's Phone & Fax: _____

PATIENT INFORMATION

*Name: _____ *Date of Birth: _____

*Member ID Number: _____ *Member Phone Number: _____

*Preferred Language: English Spanish

*Service Is: Elective/Routine Expedited/Urgent Resubmission Additional Services _____ auth

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

***REFERRAL SERVICE TYPE REQUESTED**

Inpatient	Outpatient	Behavioral Health	Other
<input type="checkbox"/> Surgical Procedure	<input type="checkbox"/> Surgical Procedure	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Home Health (SN/PT/OT/SP)
<input type="checkbox"/> Elective Admission	<input type="checkbox"/> Imaging/Diagnostic	<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> Durable Medical Equipment
<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Infusion Therapy	<input type="checkbox"/> Intensive Outpatient	<input type="checkbox"/> Dental (Facility/Anesthesia)
<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/> Exception to Benefit
<input type="checkbox"/> Lower Level of Care	<input type="checkbox"/> Radiation		<input type="checkbox"/> Out of Network Exception
	<input type="checkbox"/> Transplant Eval/Listing		

PROCEDURE INFORMATION

*ICD-10 Diagnosis: _____ Diagnosis Description: _____

*CPT/HCPCS Code and Description (For PT, OT or ST, please indicate if Rehabilitative or Habilitative.) (Include units of measure/visits and please indicate if Robotic Assisted and include all implant codes) _____

* Date(s) of Service: _____ * Number of Visits: _____

PROVIDER INFORMATION

Ordering Provider:

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Servicing Provider:

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Facility/Office Location:

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Request for extension to authorization:

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

RETRO AUTHORIZATIONS CAN BE SUBMITTED UP TO 10 BUSINESS DAYS AFTER DATE OF SERVICE UNLESS EXTENUATING CIRCUMSTANCES ARE PRESENT.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time 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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