

Requestor's Contact Name:				Requestor's Contact #:			
<b>Patient Information:</b>							
*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"/> Part A	<input type="checkbox"/> Part B
*Service Is: <input type="checkbox"/> Elective / Routine		<input type="checkbox"/> Expedited / Urgent		Retrospective review			
<b>Note:</b> Select Expedited/Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.							
(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-800-809-9361)							
<b>*Referral Service Type Requested:</b> Please review plans benefit prior to request							
<b>Inpatient</b>		<b>Outpatient</b>		<b>Behavioral Health</b>		<b>Other</b>	
<input type="checkbox"/> Emergent Inpatient <input type="checkbox"/> Concurrent Review <input type="checkbox"/> Surgical Procedures <input type="checkbox"/> Elective Admission <input type="checkbox"/> Elective Observation <input type="checkbox"/> SNF <input type="checkbox"/> Rehab <input type="checkbox"/> Maternity <input type="checkbox"/> NICU		<input type="checkbox"/> Surgical Procedure PT, OT, ST Imaging Chiropractic		<input type="checkbox"/> Inpatient <input type="checkbox"/> Partial Hospitalization <input type="checkbox"/> Intensive Outpatient (IOP) <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Mental Health & Substance Use Disorder <input type="checkbox"/> ABA Therapy/Services <input type="checkbox"/> Other Therapy:		<input type="checkbox"/> Home Health /Skilled Services (SN/PT/OT/SP) <input type="checkbox"/> Private Duty Nursing <input type="checkbox"/> DME <input type="checkbox"/> Transportation / Transfers <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Other:	
<b>Procedure Information:</b>							
*ICD 10 Diagnosis:				Diagnosis Description:			
*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies):							
*Date(s) of Service:				Number of Visits:			
<b>Provider Information:</b>							
<b>Ordering Provider</b>				Is this the member's Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
*Name:		*NPI:		TIN:			
*Phone:		*Fax:					
*Address:							
<b>Servicing Provider</b>				Is this the same as the Ordering Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>If not complete below:</b>							
*Name:		*NPI:		TIN:			
*Phone:		*Fax:					
*Address:							
<b>Facility</b>							
*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**

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.  
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 any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.