

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"/>	Part A	<input type="checkbox"/>	Part B			
*Service Is: <input type="checkbox"/> Elective / Routine				<input type="checkbox"/> Expedited / Urgent									
Note: 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)													
*Referral Service Type Requested: Please review plans benefit prior to request													
Inpatient		Outpatient		Behavioral Health		Other							
<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	<input type="checkbox"/> PT, OT, ST	<input type="checkbox"/> Imaging	<input type="checkbox"/> 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:
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 Physician? <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													

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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