

**PRE-SERVICE/
PRIOR AUTHORIZATION
REVIEW REQUEST FORM**

Fax to: 800-843-1114
**(FORM MUST BE THE FIRST 2 PAGES OF
SUBMISSION AND NOT HANDWRITTEN.)**



Request date: _____

MEMBER/PATIENT: _____ Date of birth: _____
Member ID: _____ Suffix: _____ Group #: _____

<p>REQUESTING PROVIDER: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required): _____ NPI # (required): _____</p>	<p><input type="checkbox"/> CHECK HERE IF THE SERVICING PROVIDER IS THE SAME AS THE REQUESTING PROVIDER. SERVICING PROVIDER: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (required): _____ NPI # (required): _____</p>
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REQUIRED: Complete all fields that apply for place of service. To enable Site of Service boxes download form before completing

<p>FACILITY: _____ Address: _____ City: _____ State: _____ ZIP: _____ Tax ID (required): _____ NPI # (required): _____ Phone: _____ Fax: _____</p>	<p><input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Office <input type="checkbox"/> Ambulatory surgical center <input type="checkbox"/> Ongoing treatment <input type="checkbox"/> Home <input type="checkbox"/> Other _____</p> <p>* For medical and psychiatric lower levels of care, use our Admission/Concurrent Review Fax Form.</p>
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Date scheduled: _____ **Existing reference #:** _____ **Expiration date:** _____

URGENT REQUEST - PLEASE NOTE: Scheduling issues do not meet the definition of urgent.
Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: _____

CLINICAL INFORMATION required. Attach supporting medical records and include presenting symptoms and previous treatment.

Procedure code/CPT code:	Modifier: (LT/RT/NU/RR)	Units:	ICD diagnosis code:

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

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