

Please fax this completed form to 1-844-536-2412

Date of request _____

Request to modify existing authorization – please include auth number _____

Details on modification (i.e. units or dates to change) _____

To the best of your knowledge, this request is a:

New Request Continuation Request - approximate date initiated _____

Expedited/Urgent Review Requested - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.



Physician Signature

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID*

Date of Birth*

Member Phone #

Last Name*

First Name*

REQUESTING PROVIDER INFORMATION

Requesting NPI*

Requesting TIN*

Requesting Provider Contact Name

Requesting Provider Name*

Specialty

Phone*

Fax*

SERVICING PROVIDER/FACILITY INFORMATION Same as requesting provider

Servicing NPI*

Servicing TIN*

Servicing Provider Contact Name

Servicing Provider Name*

Specialty

Phone*

Fax*

AUTHORIZATION REQUEST

Primary Procedure Code*

Additional Procedure Code

Start Date

Diagnosis Code

(CPT/HCPSS)

(Modifier)

(CPT/HCPSS)

(Modifier)

MMDDYYYY

ICD10

Additional Procedure Code

Additional Procedure Code

End Date

(CPT/HCPSS)

(Modifier)

(CPT/HCPSS)

(Modifier)

MMDDYYYY

MEDICATION REQUESTED

Medication Name*

Dose Per Visit*

Frequency*

Total Number of Visits*

Rationale for request and pertinent clinical information is required for all prior authorizations and should be attached to this request. Lack of clinical information may result in delayed determination

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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