

PRIOR AUTHORIZATION/REFERRAL FAX FORM

☐ Request for additional units. Existing Authorization Units

☐ Standard Request - Determination within 5 working days of receiving all necessary information, not to exceed 14 calendar days from receipt.

☐ Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

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

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member Phone Number Date of Birth *

Member ID/Medicaid ID * Last Name, First

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI * Requesting TIN * Requesting Provider Contact Name

Requesting Provider Name Phone Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

Servicing NPI * Servicing TIN * Servicing Provider Contact Name

Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

Primary Procedure Code * Additional Procedure Code Start Date OR Admission Date * Diagnosis Code *

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)

Additional Procedure Code Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)

OUTPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes)

422 Biopharmacy	141 Imaging Services	470 Personal Care Worker Services
401 Cardiac Pulmonary Rehab	211 OB Ultrasound(s)	101 Physical Therapy
771 Dialysis	790 Occupational Therapy	325 Podiatry Office Visit
	497 Office Visit/Specialty Consult	201 Sleep Study
DME	927 Outpatient Hospice	701 Speech Therapy
417 Rental	794 Outpatient Services	
120 Purchase <input type="text"/>		Surgery
(Purchase Price)		400 Inpatient
	Pain Management	427 Outpatient
299 Drug Testing	429 Office Visit	724 Transportation
709 Genetic Testing	170 Other Site	
249 Home Health		

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. 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.

Confidentiality: The information contained in this 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.

For Medicare Prior Authorization Requests-Please fax to 877-687-1183.