

REQUEST FOR AUTHORIZATION OF SERVICES

FAX REQUEST TO: (800) 513-0740

Prior authorization is required for services by any non-participating provider and for certain services by participating providers. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage.

Authorization Reque	est							
Member name:			DOB	:/	/ Memb	er ID:		
Nursing facility:								
Requesting provider / type:				NPI / TIN:				
Phone number: ()			Fax number: ()					
Primary diagnosis:								
Diagnoses (ICD-10 code	es) related to auth. re	equest:						
Servicing provider / type	:			NPI / TIN	۱:			
Servicing provider phone	e number: ()	S	ervicing pr	ovider fax nu	mber: ()		
Include all clinical docu medical necessity decisi						v clinical require	d to make a	
Inpatient admit Observation Behavioral health ac Start date for service checked above (mandatory) : / /								
DME New patient: non-participating physician office visit Follow-up: non-participating physician office							office visit	
Procedure code(s) / quantities: Scheduled date for services: /								
Diagnostic testing or pro								
	Procedure code(s): Scheduled date for services: / /							
Request for Part B then Request is for: Initial		·		Procedure		SOC	Evaluation	
	requested							
Physical therapy		W						
Occupational therapy		W						
Speech therapy		W						
Home health aide		W					N/A	
To be completed by Standard authoriz	person requesting		Expe	edited autho	rization (mu	st read and sigr	n): By signing	
completed and includin documentation) are conguidelines. Our goal is	mpleted within 14 da			ne could plac		ecision under the er's life, or healt		
Signature:					Date	completed:	_//	
Name of person complete	- "	print):						
Notification will be faxed	•	•	•					
Who is receiving authori								
Contact phone number: This authorization is NOT a to denial of payment. This f may not be copied or disser	guarantee of eligibility acsimile message is pr	or payment. Any services ivileged and confidential. I	s rendered b It is transmit	eyond those a ted for the exc	uthorized or ou lusive use of t	utside approval da he addressee. Th	ites will be subject is communication	