

REQUEST FOR AUTHORIZATION OF SERVICES

PARTICIPATING PROVIDERS: Please refer to Section III for the list of services that require prior authorization.

NON-PARTICIPATING PROVIDERS: Please refer to Section III for the list of services that require prior authorization. An authorization is not a guarantee of payment and is only for the services indicated below. Payment is subject to the limitations and exclusions as outlined in the Member Evidence of Coverage.

Section I: Member Information

Member Name: _____ Date of Birth: _____ Member ID: _____

Ordering Provider: _____ Phone No.: _____ Fax No.: _____

Primary Diagnosis (ICD-10 and Description): _____

Reason for Service Request: _____

Section II: Requesting Provider/Requesting Facility Information

Rendering

Facility Name _____ Street Address _____

Facility Phone _____ City, ST, ZIP _____

Facility Fax _____ Facility NPI _____ Facility Tax ID _____

Rendering

Provider Name _____ Street Address _____

Provider Phone _____ City, ST, ZIP _____

Provider NPI _____ Provider Tax ID _____

Section III: Services Requested (include copy of order or clinical note)

Start Date: _____ End Date: _____

- Acute Rehabilitation Facility
- Air Ambulance
- Durable Medical Equipment (DME) (>\$500)
- Home Health Services
- Hospital
 - Inpatient
 - Long-Term Acute Care (LTAC)
 - Outpatient Surgery
 - Psychiatric
- Mental Health Specialty Services
- Part B Drugs (>\$1,000) (chemo, injectables, etc.)
- Rehab: Cardiac/Pulmonary
- Skilled Nursing Facility (non-participating SNF)
- Transplant
- Wound Care Management Products (cellular and tissue-based products, etc.)



REQUEST FOR AUTHORIZATION OF SERVICES, continued

CPT or HCPC Code(s)	Description	# of Visits/Injections

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

- Standard Authorization:** Authorizations will be processed within 7 days of receipt.
- Expedited Authorization (Must Read and SIGN):** By signing below, I certify that waiting for a decision under the standard time frame could place the Member's life or health in serious jeopardy.

SIGNATURE:

Name of Person Completing this Form:

Date Completed:

Contact #:

Authorization Notification Fax:

To check on the status of an authorization or for other questions, please call 1-833-215-9332.

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

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