

Requestor's Contact Name:		Requestor's Contact #:	
Patient Information:			
*Name:		*DOB:	
*Member ID #:		*Member Phone #:	
Work Related Injury?	☐ Yes ☐ No	Motor Vehicle Accident related injury?	☐ Yes ☐ No
Does the member have other insurance?		If Yes, other insurer	
Does the member have Medicare?		If Yes, Part A Part B	
*Service Is: ☐ Elective / Routine ☐ Expedited / Urgent ☐ Retrospective Review			
Note: Select Expedited/Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.			
(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-800-817-3056)			
*Referral Service Type Requested: Please review plans benefit prior to request			
Inpatient	Outpatient	Behavioral Health	Other
☐ Emergent Inpatient ☐ Concurrent Review ☐ Surgical Procedures ☐ Elective Admission ☐ Elective Observation ☐ SNF ☐ Rehab ☐ Maternity ☐ NICU	☐ Surgical Procedure ☐ PT, OT, ST ☐ Imaging ☐ Chiropractic	☐ Inpatient ☐ Partial Hospitalization ☐ Intensive Outpatient (IOP) ☐ Residential Treatment ☐ Mental Health & Substance Use Disorder ☐ ABA Therapy/Services ☐ Other Therapy:	☐ Home Health /Skilled Services (SN/PT/OT/SP) ☐ Private Duty Nursing ☐ DME ☐ Transportation / Transfers ☐ Air Ambulance ☐ Other:
Procedure Information:			
*ICD 10 Diagnosis:		Diagnosis Description:	
*CPT/HCPC Code & Description (Include requested Units of Measure / Frequency for supplies):			
*Date(s) of Service:		Number of Visits/Units:	
Provider Information:			
Ordering Provider		Is this the member's Primary Care Physician? ☐ Yes ☐ No	
*Name:		*NPI: TIN:	
*Phone:		*Fax:	
*Address:			
Servicing Provider		Is this the same as the Ordering Provider? ☐ Yes ☐ No	
If not complete below:			
*Name:		*NPI: TIN:	
*Phone:		*Fax:	
*Address:			
Facility			
*Name:		*NPI: TIN:	
*Phone:		*Fax:	
*Address:			
Request for extension to authorization request:			
ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS. Always verify eligibility, benefits and prior authorization requirements			
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 the 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.			