

Requestor's Contact Name:				Requestor's Contact #:					
Patient Information:									
*Name:				*DOB:					
*Member ID #:				*Member Phone #:					
Work Related Injury?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Motor Vehicle Accident related injury?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does the member have other insurance?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes, other insurer:				
Does the member have Medicare?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If Yes,	<input type="checkbox"/>	Part A	<input type="checkbox"/>	Part B
*Service Is: <input type="checkbox"/> Elective/Routine				<input type="checkbox"/> Expedited/Urgent					
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 844-865-8059)									
*Referral Service Type Requested: Please review plans benefit prior to request									
Inpatient			Outpatient			Other			
<input type="checkbox"/> Emergent Inpatient Admission <input type="checkbox"/> Concurrent Review <input type="checkbox"/> Long-Term Acute <input type="checkbox"/> SNF <input type="checkbox"/> Rehab <input type="checkbox"/> Transplant <input type="checkbox"/> Maternity <input type="checkbox"/> Elective Admission/Surgery			<input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Imaging <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Pain Management <input type="checkbox"/> Cosmetic/Reconstructive <input type="checkbox"/> Sleep Study			<input type="checkbox"/> DNA/Genetic Testing <input type="checkbox"/> Orthotics/Prosthetics > \$750 <input type="checkbox"/> Lab Services <input type="checkbox"/> Other: Click here to enter text.			
Procedure Information:									
*ICD 10 Diagnosis:				Diagnosis Description:					
*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies):									
*Date(s) of Service:				Number of Visits:					
Provider Information:									
Ordering Provider				Is this the member's Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No					
*Name:		*NPI:		TIN:					
*Phone:		*Fax:							
*Address:									
Servicing Provider				Is this the same as the Ordering Provider? <input type="checkbox"/> Yes <input type="checkbox"/> 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									
<small>Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of 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 and use, distribute, or coping is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.</small>									