

Standard Request - Determination within 14 working days of receiving all necessary information

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.

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

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth *

 (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

 (CPT/HCPCS) (Modifier)

Start Date OR Admission Date *

 (MMDDYYYY)

Diagnosis Code *

 (ICD-10)

Additional Procedure Code

 (CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity

 (MMDDYYYY)

INPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

Delivery	121 Long Term Acute Care	Transplant
779 C-Section	970 Medical	209 Surgery
720 Vaginal Delivery	414 Premature/False Labor	419 Work-up
929 Hospice Inpatient	402 Skilled Nursing Facility	
	492 Sub-Acute	
	411 Surgical	
Inpatient Rehab		
479 Inpatient Hospital		
220 Comprehensive Inpatient Rehab Facility		

**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.

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