

necessary with prior authorization as per Plan policy and procedures.

Inpatient Admission Notification Fax #: 1-800-385-4169 Post Discharge Services UM Fax #: 1-833-424-8013

Scheduled Inpatient & Outpatient Services & Transplant Request Fax #: 1-800-953-8856

Requestor's Contact Name: Requestor's Phone #:		
Patient Information:		
*Name: *DOB:		
*Patient ID #:	ient ID #: *Patient Phone #:	
*Service Is: Elective / Routine 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 1-800-953-8854)		
*Service Type Requested: Please review plans benefit prior to request		
Inpatient	Outpatient	Other
☐ Emergent Inpatient	☐ Surgical Procedure	
☐ Concurrent Review	☐ Chiropractic Services	☐ Home Health /Home Infusion/ IVT
☐ Surgical Procedures	☐ Cochlear Implants	☐ Private Duty Nursing
☐ Elective Admission	☐ Hyperbaric Oxygen Therapy	☐ Hospice Care
☐ Skilled Nursing Facility	☐ Intensive Cardiac & Pulmonary Rehab	☐ Hearing Aids/ Cochlear Implants
☐ Acute Rehab	□ Podiatry Services	☐ DME/Prosthetics/Orthotics
☐ Maternity	☐ Sleep Study	☐ High Cost Medication
□ NICU Stay		☐ Voluntary Sterilization
	☐ Transplant Evaluations	,
☐ Transplant	☐ Bariatric Surgery	
		☐ Other:
		a other.
Procedure Information:		
*ICD 10 Diagnosis: Diagnosis Description:		
*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies):		
*Date(s) of Service: # of Units or Visits:		
Provider Information:		
Requesting Provider Is this the patient's Primary Care Physician?		
*Name:	*NPI TIN:	
*Phone:	*Fax	THV.
*Address:		
Rendering Provider		
If Requesting and Rendering providers differ, complete section below		
*Name:	*NPI	*TIN:
*Phone:	*Fax	
*Address:		
Facility	□ N/A *NPI	*TIN:
*Name: *Phone:	*Fax	· TIN:
*Address:		
Request for extension to existing authorization number:		
PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK AND 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 of services are rendered. Services must be a covered Health Plan Benefit and medically		

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