MARYLAND physicians care
MANAGED CARE ORGANIZATION

Inpatient Admission Notification Fax #: 1-800-385-4169
Post Discharge Services UM Fax #: 1-855-905-5936
Scheduled Inpatient & Outpatient Services & Transplant Request Fax #: 1-800-953-8856

*Requestor's Contact Name: *Requestor's Contact #:

Patient Information:

*Name: *DOB:

*Patient ID #: *Patient Phone #:

*Service Is: Elective / Routine Expedited / Urgent

Note: Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function

*Does the Member have other insurance? Yes No If Yes, other insurer

***Service Type Requested:** Please review plans benefit prior to request

Inpatient	**Outpatient**	**Other**
Fax to 1-800-385-4169	Surgical Procedure	Home Health
Emergency Admission ***(No CPT Code required)***	Chiropractic Services	Private Duty Nursing
OB/Maternity	Cardiac Rehab	Home Infusion/ IVT
NICU/Detained/Sick Baby	Audiology Services/DME	Hospice Care ****CTI required***
Transplant Admission	Hyperbaric Oxygen Therapy	Prosthetics/Orthotics
Fax to 1-855-905-5936	Pulmonary Rehab	Neuropsych Testing
Skilled Nursing Facility/Acute Rehab	Sleep Study	Genetic Testing
Hospice ****CTI Required***	Transgender Procedure	Enteral Formula/TPN & Supplies ****Enteral/Nutritional Supplement Form Required***
Discharge Planning Services	Transplant Evaluation	DME Purchase ___________
Fax to 1-800-953-8856	Voluntary Sterilization ****Sterilization Consent Form Required***	DME Rental ___________
Transplant Listing	Other ___________________________	****Pharmacy Medication Requests*** *Submit on Medical Benefit RX Request Form*
Elective Admission		
Surgical Procedure		

Procedure Information:

***ICD 10 Diagnosis:** Diagnosis Description:

***CPT/HCPCS** Code *(Include Unit per CPT/HCPCS Code):*

***Date(s) of Service:** ***# of Units/Visits:**

Provider Information:

Requesting Provider Is this the patient's Primary Care Physician? ____ Yes ☐ No

*Name: *NPI TIN:

*Phone: *Fax

*Address:

Rendering Provider Same as the Requesting Provider

If Requesting and Rendering providers differ, complete section below

*Name: *NPI *TIN:

*Phone: *Fax

*Address:

Facility ☐ N/A

*Name: *NPI *TIN:

*Phone: *Fax

*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 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.