



ANCILLARY AUTHORIZATION REQUEST

Fax To: (888) 881-8225

Check One of the Following

- DME, Home Care Services, PT/OT/ST, Transition of Care

\*Required Information - In order to ensure our members receive quality care, appropriate claims payment and notification of servicing providers, all required fields on this form must be completed. Please type or print in black ink and submit this request to the fax number above. For an urgent\* request, do not fill-out this form. Please call Medicare at (888)-505-1201 or Medicaid at (888) 846-4262..

Member

Member Plan ID, Today's Date, Date of Birth, Member Last Name, Member First Name, Member Phone Number, Member Contact Name, Member Address

Requesting Provider

Provider ID, Type: PCP/Specialist, Provider Last Name, Provider First Name, Phone Number, Fax Number, Specialty, RP Contact

Treating Provider

Provider ID, Specialty, Provider Last Name, Provider First Name, Provider Address, City/State/Zip Code, Phone Number, Fax Number

Facility

Check this box to skip this section and have the Plan assign the Facility

Type: Office/OP Hospital/Free Standing Facility, Medical Record Number, Facility ID, Facility Name, Address, City/State/Zip Code, Phone Number, Fax Number

Service Requested

Planned Date of Service, From: / /, To: / /

Primary ICD-9 Code, Description

Table with 3 columns: CPT-4/HCPC, DESCRIPTION OF PROCEDURE OR SERVICES, VISITS/FREQUENCY

Please include a clinical summary below including additional procedure codes as applicable. Attach supporting clinical records, if necessary.

Blank area for clinical summary

Date: Ordering Physician/Requesting Provider Signature: