



OUTPATIENT AUTHORIZATION REQUEST

Fax To: (888) 881-8225

Check One of the Following

Grid of checkboxes for Consultation, Follow-Up Visit, Diagnostic Testing, Office Procedure, Ambulatory Surgery, Dialysis, Radiation Therapy, Out of Network Provider, OB Services.

Transition of Care? YES NO

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, Member Last Name, Member First Name, Member Phone Number, Date of Birth

Requesting Provider

Provider ID, Type (PCP, Specialist), Provider Last Name, Provider First Name, Phone Number, Fax Number, Specialty, RP Contact

Treating Provider

Check this box to skip this section and have the Plan assign the Treating Provider. Provider ID, Specialty, Provider Last Name, Provider First Name, 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, EDD, Primary ICD-9 Code, Description, Table with columns: CPT-4/HCPC, DESCRIPTION OF PROCEDURE OR SERVICES, VISITS/FREQUENCY

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

Large empty box for clinical summary and supporting records.