

Prior Authorization Request Form



Fax Requests to **1-833-263-4869**

Patient Name: _____

Member ID: _____

Date of Birth: ____ / ____ / ____

Phone Number (____) _____

Please select service(s) for which you are requesting prior authorization.

- Home Health Care
- BRAC gene testing
- Integrated Oncology/Radiation Therapy Power
- Operated Vehicles (CMN required)
- Durable Medical Equipment (DME)

Expedited
Read Definition below prior to checking box.
Check expedited **ONLY** if it meets the definition of expedited request per CMS Guideline 50 - Expedited Organization Determination: Enrollee/Physician believes that waiting for a decision under the standard time frame (14 days) could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

- Inpatient Rehabilitation/Long Term Acute Care Admit Part B Therapy
- Part B Drugs/Chemotherapy Drugs
- Transplant Evaluation or Transplant
- Hyperbaric Oxygen

Other: _____

Elective Procedure: please select expected bed type below

- Inpatient Observation Outpatient

Requesting Provider's Name: _____	
Provider's Phone: (____) _____	Provider's Fax: (____) _____
Name of Person Completing Request: _____ Contact Phone:(____) _____	
Servicing Facility (if applicable): _____	
Facility NPI: _____	Facility TIN: _____
Servicing Provider: _____	
Provider NPI: _____	Provider TIN: _____
Provider's Phone: (____) _____	Provider's Fax: (____) _____

Start Date: Frequency: _____

Applicable Diagnoses & ICD-10 Codes: _____

Service Description and Code(s): _____

Medical Rationale for Request: _____

OUT-OF-NETWORK CARE for HMO Members (does not apply for PPO members): Out-of-network care is only considered when services are not accessible in-network.

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