OUTPATIENT PRIOR AUTHORIZATION FORM

Physical Health: 833-941-0445
Biopharmacy : 844-235-5090
Transplant:833-941-0452
Behavioral Health: 833-941-0448
Concurrent Review: 833-941-0450
Urgent Request Fax: 800-977-7522

☐ **Standard Requests -** Determination within 7 calendar days of receipt of request--Used for Scheduled Admissions.

☐ **Urgent Requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

*** Indicates Required Field**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

Member ID*

Last Name, First

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

*Servicing Provider Address

*City

*State

*Zip

AUTHORIZATION REQUEST

*Primary Diagnosis Code (ICD-10)

Place of Service Codes Full List: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

*Primary Procedure Code (CPT/HCPCS) (Modifier)	*Start Date OR Admission Date (MMDDYYYY)	End Date OR Discharge Date (MMDDYYYY)	Total Units/Visits/Days	*Place Of Service Code

Additional Procedure Code (CPT/HCPCS) (Modifier)	Start Date OR Admission Date (MMDDYYYY)	End Date OR Discharge Date (MMDDYYYY)	Total Units/Visits/Days	Place Of Service Code

Additional Procedure Code (CPT/HCPCS) (Modifier)	Start Date OR Admission Date (MMDDYYYY)	End Date OR Discharge Date (MMDDYYYY)	Total Units/Visits/Days	Place Of Service Code

Additional Procedure Code (CPT/HCPCS) (Modifier)	Start Date OR Admission Date (MMDDYYYY)	End Date OR Discharge Date (MMDDYYYY)	Total Units/Visits/Days	Place Of Service Code

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time 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 this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the

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