

ANCILLARY SERVICES AUTHORIZATION REQUEST

*** Check one of the following:**

Fax To: 877-431-8859

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

***Required Information** – 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. **Do not use this form for an urgent^ request. Please call (800) 925-3606.**

* Today's Date: ___/___/___

Member

* Member Plan ID: _____ * DOB: ___/___/___
 * Member Last Name: _____ * Member First Name: _____
 Member Phone Number: _(_____)_____

Requesting Provider

* Provider ID: _____ * Type: PCP ___ Specialist___
 * Provider Last Name: _____ * Provider First Name: _____
 Address: _____ *City: _____ *State: _____ *Zip: _____
 Phone Number: _(_____)_____ * Fax No.: _(_____)_____
 * Specialty: _____ * RP Contact: _____

Treating Provider

* Provider ID: _____ * Specialty: _____
 * Provider Last Name: _____ * Provider First Name: _____
 * Address: _____ *City: _____ *State: _____ *Zip: _____
 * Phone Number: _(_____)_____ * Fax No.: _(_____)_____

Facility

* Type: Free Standing Facility
 Check this box to skip this section and have the Plan assign the Facility
 * Facility ID: _____ * Facility Name: _____
 * Address: _____ *City: _____ *State: _____ *Zip: _____
 * Phone Number: _(_____)_____ * Fax No.: _(_____)_____

Service Requested

* Planned Date of Service: From: ___/___/___ To: ___/___/___
 * Primary ICD-9 Code: _____ * Description: _____

* CPT-4 /HCPC Code	* Description of Procedure, Services	* Visits/Frequency

Please include additional procedure codes as may be applicable in the Clinical Summary below.

* Pertinent Clinical Summary: (attach supporting clinical records, if necessary). For customized equipment or services specify pertinent member information (i.e. height, weight, O₂ saturation, sleep study, functional assessment, etc.)

Authorizations will be given for medically necessary services only; it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). ^Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life threatening) which should be treated within 24 hours.