



OUTPATIENT AUTHORIZATION REQUEST

Fax To: (866) 455-6529

* Check one of the following:

- Out of Network Provider Diagnostic Testing Office Procedure Ambulatory Surgery
- Transition of Care Other

* **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

Check this box to skip this section and have the Plan assign the Treating Provider

* Provider ID: _____ * Specialty: _____

* Provider Last Name: _____ * Provider First Name: _____

* Address: _____ * City: _____ * State: _____ * Zip: _____

* Phone Number: _(_____)_____ * Fax No.: _(_____)_____

Facility

* Type: Office OP Hospital 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: ___/___/___ EDD: _____

* Primary ICD-9 Code: _____ * Description: _____

* CPT-4 /HCPC Code	* Description of Procedure, Service	* 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)

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.