

**Ancillary Services
Authorization Request**



Fax to: (877) 431-8859

CHECK ONE OF THE FOLLOWING:

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

(POS) POINT OF SERVICE BENEFIT OPTION ELECTED BY MEMBER. Higher share of cost for member will apply.

Required Information: In order to ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, please complete this form in its entirety. Please type or print in black ink and submit this request to the fax number above.

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

Provider ID: _____ Specialty: _____
 Provider Last Name: _____ Provider First Name: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Phone Number: _____ Fax Number: _____

FACILITY

Type: Office OP Hospital Free Standing Facility Home Ambulette Medical Record Number: _____

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 Number: _____

SERVICE REQUESTED

Planned Date of Service: From: ___/___/___ To: ___/___/___

Primary ICD-9 Code: _____ Description: _____

CPT- 4 / HCPC Code	Description of Procedure or Services	Visits / Frequency	Total Amount Billed (DME)

Please include additional procedure codes, as 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.)