

Outpatient Notification / Authorization Request Form



Fax To:

Connecticut	877-892-8215	Florida	877-892-8216	Georgia	877-892-8213
Illinois	877-899-2044	Indiana	888-275-8211	Louisiana	866-455-6488
Missouri	877-899-2033	New Jersey	877-892-8221	New York	877-892-8214
Ohio	877-851-2048	Texas	877-894-2034		

CHECK ONE OF THE FOLLOWING:

- Consultation
 Follow-up Visit
 Diagnostic Testing
 Office Procedure
 Ambulatory Surgery
 Dialysis
 Radiation Therapy
 Out of Network Provider
 OB Services
 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

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 Number: _____

FACILITY

Type: Office OP Hospital Free Standing Facility 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: ___ / ___ / ___ EDD: _____
 Primary ICD-9 Code: _____ Description: _____

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

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

Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).