



Notification/Authorization Form (Medicare Only)

Failure to provide fax number will delay processing of request.

Please send the requested information by fax.

Fax #:	FL: <u>877-431-8860</u> <small>(Inpatient requests)</small>	NY: <u>877-431-8860</u> <small>(Inpatient requests)</small>	LA: <u>877-431-8860</u> <small>(Inpatient requests)</small>
	FL: <u>800-935-5752</u> <small>(outpatient requests)</small>	NY: <u>800-246-7983</u> <small>(outpatient requests)</small>	LA: <u>877-766-3131</u> <small>(outpatient requests)</small>
	IN: <u>877-431-8860</u> <small>(Inpatient requests)</small>	IL: <u>877-431-8860</u> <small>(Inpatient requests)</small>	CT: <u>866-455-6529</u> <u>203-239-0016</u> <small>(CMR Inpatient requests) (CMD Inpatient requests)</small>
	IN: <u>866-204-6392</u> <small>(outpatient requests)</small>	IL: <u>866-867-9953</u> <small>(outpatient requests)</small>	CT: <u>800-246-7983</u> <small>(outpatient requests)</small>

Request Type: Routine Stat Expedited

- Refer to Quick Reference Guide to determine which services require authorization versus notification.
- If request is notification, you will not receive an authorization confirmation number. You may want to send a copy of your written request with the patient to the specialist.
- The authorization is valid for up to 3 visits or 60 days unless otherwise specified.
- Routine participating office labs, PCP visits, plain X-rays, immunizations and EKGs do not require notification or authorization.

Fill in the following for both notification and authorization:

Request Date: _____

Member Information:

Last: _____ First: _____ Member I.D.: _____ DOB: _____

Requesting Provider Information:

PCP Last: _____ PCP First: _____ PCP Fax #: _____

Rendering Provider Information:

Provider ID #: _____ Provider phone #: _____ Provider Fax #: _____
 Specialist Name: _____ Specialist Address: _____
 Facility Name: _____ Facility Address: _____
 Facility Type: Inpatient Hospital
 Outpatient Hospital
 Freestanding Outpatient or Facility
 23-Hour Observation

Clinical Information:

ICD-9 _____ Diagnosis Description: _____
 CPT Code(s): _____ CPT Description: _____

Authorization: Indications for surgery/procedure (please attach consultation notes and/or progress report):

For Notification Only: (check boxes that apply)

- Specialist consultation with/without treatment
- Physical Therapy (Initial 3 visits)
- Speech Therapy (Initial 3 visits)
- Occupational Therapy (Initial 3 visits)

M.D. / D.O. Signature _____ Date _____

Note: Authorization will be given for medically necessary services only; it is not a guarantee of payment. Eligibility will be authenticated prior to payment. Payment is subject to verification of eligibility and to the limitations and exclusions of the member's contract.