



# Vendor Point of Service (POS)\* Authorization Request

**Fax To: (877) 544-2012**

**Required Information:** In order for the **Member POS\* Benefit Option** to be enacted and 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. \* **Higher share of cost for the member will apply.**

<b>CHECK ONE OF THE FOLLOWING:</b>				
<input type="checkbox"/> Consultation	<input type="checkbox"/> Follow-up Visit	<input type="checkbox"/> Diagnostic Testing	<input type="checkbox"/> Office Procedure	<input type="checkbox"/> Ambulatory Surgery
<input type="checkbox"/> Home Health	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Rehab Therapies	<input type="checkbox"/> DME	<input type="checkbox"/> Behavioral Health
<b>MEMBER</b>				
Member Plan ID:		Today's Date:		
Member Last Name:		Member First Name:		
Member Phone Number:		Date of Birth:		
<b>REQUESTING PROVIDER</b>				
Provider ID:		Type:	<input type="checkbox"/> PCP	<input type="checkbox"/> Specialist
Provider Last Name:		Provider First Name:		
Phone Number:		Fax Number:		
Specialty:		RP Contact:		
<b>TREATING PROVIDER</b>				
<input type="checkbox"/> 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:		
<b>FACILITY</b>				
Type:	<input type="checkbox"/> Office	<input type="checkbox"/> OP Hospital	<input type="checkbox"/> Free Standing Facility	Medical Record Number:
<input type="checkbox"/> 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:		
<b>SERVICE REQUESTED</b>				
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).				
_____				
_____				

*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.*