



AUTHORIZATION REQUEST FORM

Please fill out this form completely and legibly. If you have questions or need assistance completing this request form, please call (866) 270-5223.

CHOOSE THE APPROPRIATE REQUEST TYPE

Standard Request

Allow two (2) business days for review of prior authorization requests with receipt of clinical information and valid codes. If a response has not been received after two (2) business days, please contact Health Services to confirm that your request was received.

Expedited Request

By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Priority Request

Please process ASAP as these services are scheduled on:

_____/_____/_____
Month Day Year

Additional Visits Request

Please review the following additional information to support our request for _____ additional visits on Authorization Number _____.

Signature Validating Expedited Request: _____ Date: _____

MEMBER INFORMATION

Member Name: _____ Member ID: WX _____
Reference/Authorization Number (if available): _____ Member DOB: _____

PROVIDER INFORMATION

Ordering Physician: _____ Tax ID/NPI: _____
First MI Last
Person Completing Form: _____ Phone: _____ Fax: _____
First Last
Facility/Place of Service: _____ Tax ID: _____
Facility Name or First MI Last NPI: _____
Address: _____
Phone: _____ Fax: _____

CLINICAL INFORMATION – Please fax any relevant clinical information for review.

<input type="radio"/> INPATIENT	<input type="radio"/> Observation <input type="radio"/> LTAC	<input type="radio"/> Medical <input type="radio"/> SNF/Swing/Sub-Acute	<input type="radio"/> Surgical	<input type="radio"/> Behavioral Health <input type="radio"/> Rehab
<input type="radio"/> OUTPATIENT	<input type="radio"/> Testing <input type="radio"/> Therapy—PT/OT/ST <small>Requires signed physician order</small>	<input type="radio"/> Radiology	<input type="radio"/> Surgery <input type="radio"/> Other Outpatient Rehab:	<input type="radio"/> Behavioral Health <input type="radio"/> Ambulance <small>Requires signed CMN</small> <input type="radio"/> Pharmacy-Part B

Dates of Service: _____ Qty of Days/Visits Requested: _____
Diagnosis: _____ ICD-9 Code: _____
Service/Procedure(s): _____
CPT-Procedure Code(s): _____

Please attach/fax any relevant clinical information for review--including H&P, symptoms, diagnostics, labs, office notes, treatment plans, etc. Requests will be processed when all necessary information is received.

FAX this completed request and ALL supporting documentation to the applicable department fax.

Inpatient/LTAC: (615) 782-7822 ♦ SNF/Rehab: (615) 782-7868 ♦ Outpatient: (615) 782-7842
Behavioral Health: (615) 782-7901

If the determination is to deny a pre-service request, a letter noting the denial and appeal information will be mailed to the member and a copy will be faxed to the provider according to Medicare regulations.