



# ANCILLARY SERVICES AUTHORIZATION REQUEST

Fax to: 877-431-8859

\* Check one of the following:

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

**\*Required Information** – In order to ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, all required fields on this form must be completed. Please type or print in black ink and submit this request to the fax number above. \*Do not use this form for an urgent request, call (800)-951-7719.

Member

\* Today's Date: \_\_\_/\_\_\_/\_\_\_

\* Member Plan ID: \_\_\_\_\_

\* DOB: \_\_\_/\_\_\_/\_\_\_

\* Member Last Name: \_\_\_\_\_

\* Member First Name: \_\_\_\_\_

Member Phone Number: \_(\_\_\_\_\_)\_\_\_\_\_

Requesting Provider

\* Provider ID: \_\_\_\_\_

\* Type: \_\_\_ PCP: \_\_\_ Specialist

\* Provider Last Name: \_\_\_\_\_

\* Provider First Name: \_\_\_\_\_

\* Address: \_\_\_\_\_

\* Phone Number: \_(\_\_\_\_\_)\_\_\_\_\_

\* Fax No.: \_(\_\_\_\_\_)\_\_\_\_\_

\* Specialty: \_\_\_\_\_

\* RP Contact: \_\_\_\_\_

Requesting Provider

\* Provider ID: \_\_\_\_\_

\* Specialty: \_\_\_\_\_

\* Provider Last Name: \_\_\_\_\_

\* Provider First Name: \_\_\_\_\_

\* Phone Number: \_(\_\_\_\_\_)\_\_\_\_\_

\* Fax No.: \_(\_\_\_\_\_)\_\_\_\_\_

Facility

\* Type:  Free Standing Facility

Check this box to skip this section and have the Plan assign the Facility

\* Facility ID: \_\_\_\_\_ \* Facility Name: \_\_\_\_\_

\* Phone Number: \_(\_\_\_\_\_)\_\_\_\_\_ \* Fax No.: \_(\_\_\_\_\_)\_\_\_\_\_

Service Requested

\* Planned Date of Service: From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_

\* Primary ICD-9 Code: \_\_\_\_\_ \* Description: \_\_\_\_\_

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

Please include additional procedure codes as may be 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, O<sub>2</sub> saturation, sleep study, functional assessment, etc.)

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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.