

Elective Request

Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth *

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code *

(CPT/HCPCS)

(Modifier)

Start Date OR Admission Date *

(MMDDYYYY)

Diagnosis Code *

(ICD-10)

Additional Procedure Code

(CPT/HCPCS)

(Modifier)

Discharge Date (if applicable) otherwise

Length of Stay will be based on Medical Necessity

(MMDDYYYY)

INPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

Delivery

779 C-Section
720 Vaginal Delivery

970 Medical
402 Skilled Nursing Facility
411 Surgical

929 Hospice Inpatient

Transplant

209 Surgery
419 Work-up

Inpatient Rehab

479 Inpatient Hospital
220 Comprehensive Inpatient
Rehab Facility

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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