

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-844-243-5175)

PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.

Requestor's Contact Name:		Requestor's Contact #:	
Patient Information:			
*Name:		*DOB:	
*Medicaid ID		*Patient Phone #:	
*Service Is: <input type="checkbox"/> Standard <input type="checkbox"/> Expedited Reason for Expedited:			
Note: Documentation from a physician needs to be attached for expedited requests detailing the issue(s) that document could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function			
Service Type Requested: Please review plans benefit prior to request *Place of Service:			
Inpatient		Outpatient	
<input type="checkbox"/> Emergent Inpatient <input type="checkbox"/> Concurrent Review <input type="checkbox"/> Observation Stay >48 hrs <input type="checkbox"/> Surgical Procedures <input type="checkbox"/> Elective Admission <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Long-Term Acute Care <input type="checkbox"/> Acute Rehab <input type="checkbox"/> Maternity <input type="checkbox"/> NICU Stay <input type="checkbox"/> Hospice <input type="checkbox"/> Transplant		<input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Chiropractic Services <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Imaging <input type="checkbox"/> Sleep Study <input type="checkbox"/> Pain Management <input type="checkbox"/> Colonoscopy / EGD <input type="checkbox"/> Intensive Cardiac & Pulmonary Rehab <input type="checkbox"/> Pre/Post Transplant Services	
Other			
<input type="checkbox"/> Home Health /Skilled Services <input type="checkbox"/> (SN/PT/OT/SP) <input type="checkbox"/> Private Duty Nursing <input type="checkbox"/> (see PDN specific form) <input type="checkbox"/> DME <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Prosthetics/Orthotics <input type="checkbox"/> Transportation / Transfers <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Other:			
Procedure Information:			
*ICD 10 Diagnosis:		Diagnosis Description:	
*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies):			
*Date(s) of Service:		# of Units or Visits:	
Provider Information:			
Requesting Provider		Is this the patient's Primary Care Physician? <input type="checkbox"/> Yes. <input type="checkbox"/> No	
*Name:		*NPI	TIN:
*Phone:		*Fax	
*Address:			
Rendering Provider		<input type="checkbox"/> Same as the Requesting Provider	
<i>If Requesting and Rendering providers differ, complete section below</i>			
*Name:		*NPI	TIN:
*Phone:		*Fax	
*Address:			
Facility		<input type="checkbox"/> N/A	
*Name:		*NPI	TIN:
*Phone:		*Fax	
*Address:			
Request for extension to existing authorization number:			
PLEASE COMPLETE ALL SECTIONS WITH AN ASTRICK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.			
Always verify eligibility, benefits and prior authorization requirements			
<small>Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.</small> <small>Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient and use, distribute, or coping is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.</small>			