

AUTHORIZATION REVIEW FORM FOR HEALTH CARE SERVICES

SECTION I - SUBMISSION

Issuer Name: _____

Request Date: _____

Phone: _____

Fax: _____

SECTION II - GENERAL INFORMATION

Review Type: Non-Urgent Urgent

Clinical Reason for Urgency: _____

Request Type: Initial Request. Extension Previous Authorization #: _____

Place of Service:

Inpatient Observation Outpatient

Provider Office Home Day Surgery Other: _____

SECTION III - PATIENT INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____

Gender: Male. Female Other Unknown

Subscriber Name (if different): _____

Member or Medicaid ID #: _____

Plan Name: _____

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility: Name: _____

Tax ID: _____

Phone: _____ Fax: _____

Contact Name: _____
 Address: _____
 NPI: _____
 Service Provider/Facility: Name: _____
 Tax ID: _____
 Phone: _____ Fax: _____

Address: _____
 NPI #: _____
 Requesting Provider's Signature and Date: _____

SECTION V - SERVICES REQUESTED

Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehab Mental Health/Substance Abuse Home Health (Attach MD Signed Order and Nursing Assessment) Equipment/Supplies

Planned Service/Procedure	Code (CPT, HCPCS, Revenue)	Units	Start Date	End Date	Diagnosis Description	ICD-10 Code

(Attach additional pages if needed)

Note: Attach clinical documentation to this form upon submission. Failure to complete applicable fields may delay processing.

Member Services: 1-833-201-6413 TTY:711