

**PRE-SERVICE/
PRIOR AUTHORIZATION
REVIEW REQUEST**

FAX TO: 800-843-1114



*Request Date: ___ / ___ / ___

Submit requests or check status online with the [Prospective review tool](#).

URGENT – All requests marked as urgent/expedited must include supporting documentation from the physician’s office that the application of standard timeframes for making a non-urgent determination (a) could seriously jeopardize the life or health of the patient or the ability to regain maximum function, or (b) in the opinion of a physician with knowledge of member’s medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested. ***Please be advised that a prior authorization review can take approximately 5 calendar days and a Pre-service review can take approximately 5 to 15 calendar days depending on the members plan. Urgent reviews are processed in approximately 2 business days.**

Please complete the section below (*Required Entry)

Please attach any supporting clinical including present symptoms and previous treatment.

*MEMBER NAME: _____ <small>(Last, First, Middle Initial)</small>		*Date of Birth: ___ / ___ / ___	
*Member ID: _____		Suffix _____ Group ID: _____	
*REQUESTING PROVIDER: _____		*SERVICING PROVIDER: _____	
*Address: _____		*Address: _____	
*City/State/ZIP: _____		*City/State/ZIP: _____	
*Tax ID/NPI #: _____		*Tax ID/NPI #: _____	
*Contracted Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No		*Contracted Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No	
CONTACT PERSON: _____		CONTACT PERSON: _____	
*Phone : (____) _____ *Fax : (____) _____		*Phone (____) _____ *Fax : (____) _____	
*Date Scheduled: ___ / ___ / ___ Ongoing treatment please include current reference ID: _____			
<input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient			
<u>If requested service is inpatient, please provide us Facility name address and Tax ID.</u>			
Facility Name: _____		Tax/NPI ID: _____	
Address: _____		City/State/Zip: _____	
*Procedure Code (CPT)	Diagnosis (ICD-9/I*CD-10)	Modifier: Left/Right/Bilateral	Unlisted Code Description:

*If submission of this form is more than seven days post-service, medical necessity will be reviewed upon submission of the claim.

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.
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