PRE-SERVICE/
PRIOR AUTHORIZATION
REVIEW REQUEST

FAX TO: 800-843-1114

LifeWise Assurance Company

***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:** _____ ***Date of Birth:**____/____/____

(Last, First, Middle Initial)

***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: ☐ Yes ☐ No	*Contracted Provider: ☐ Yes ☐ No
***CONTACT PERSON:**_____	***CONTACT PERSON:**_____
*Phone :(____)_____*Fax :(____)_____	*Phone (____)_____*Fax :(____)_____

***Date Scheduled:**____/____/____ **Ongoing treatment please include current reference ID:**_____

☐ Outpatient ☐ Inpatient

If requested service is inpatient, please provide us Facility name address and Tax ID.

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.