

Standard requests - Determination within 2 business days of receipt of request.

Expedited requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 24 hours to avoid complications and unnecessary suffering or severe pain.

***Indicates Required Field**

MEMBER INFORMATION

*Member 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	Additional Procedure Code	*Start Date OR Admission Date	*Diagnosis Code
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(ICD-10)
Additional Procedure Code	Additional Procedure Code	Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity	Additional Diagnosis Code
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(ICD-10)

***INPATIENT SERVICE TYPE**

(Enter the Service type number in the boxes)

220 Comprehensive Inpatient Rehab Facility
779 C-Section
479 Inpatient Rehab-Hospital
970 Medical
904 Nursing Facility (Residential/Custodial
Care)

414 Premature/False Labor
402 Skilled Nursing
411 Surgical
209 Transplant Surgery
720 Vaginal Delivery

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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