Prior Authorization Department

Phone: 1-800-766-4456
Fax : 1-877-393-8226

*Required Fields

Hospital Admissions and Outpatient Procedures
Request for Authorization

Date of Request: _____

Member ID: _____   Member Name: _____

Requesting Provider ID _____   Provider Name: _____

Provider Reference ID: _____

Request Information

*Contact Name: _____   *Contact Phone: _____   Ext.

Contact Fax: _____   Contact email: _____

*Place of Service: _____   Inpatient Hospital _____   Outpatient Hospital   Office _____

*Admission Type: _____   Emergency   Elective _____

Admit Date: _____   Discharge Date: _____

*Release of information Code: _____

Diagnosis (1 required)				
ICD-9	ICD-9 Date	Primary?	Admission Diagnosis?	

Procedures			
Procedure Code	From Date	To Date	Units

Patient Transfer Information

*If Patient is being transferred to your facility, please provide reason: _____

*If Patient is being transferred from your facility, please provide reason: _____

Procedure Modifier	Procedure Code	Modifier	Primary?

*Clinical Data to Support Request

_____

_____

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