

REQUEST FOR AUTHORIZATION OF SERVICES

EMAIL or FAX THIS FORM

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Fax: 1-877-760-3820 For questions: 1-844-854-6884

Standard	Expedited/Medically Urgent*	
Provider/Facility		
Requesting Provider Name		
NPI	Tax ID	
Phone	FaxEmail	
Servicing Provider	NPITAX ID	
Facility Name:	NPI TAX ID	
Inpatient Admission Stay	/Estimated Length of Stay	days
Observation Stay	/Estimated Length of Stay	days
Is this Level of Care Change -	- Observation to InpatientYesNo	
Part A SNF (post hospitalization	n)//	days
Part A Skill In Place	/	days
Additional Part A Days:	Reason:	
Outpatient Diagnostic Service	/ CPT: Procedures:	
Part B Drug:		
DME:		
Clinicals Required with Form Sub	<mark>mission</mark>	
Member Data		
Namo:	Data of Birth	
Name:		
Plan ID/MBI: Nursing Facility:		
	Plan NP PCP Plan PA Other	
is Requesting Provider.	Plati NP PCP Plati PA Ottlet	
Diagnosis (ICD10) Polated to Po	aguast:	
Diagnosis (ICD10) Related to Re	equest:	
Part B Therapy		
TYPE PT	OT ST	
nitial Visits: Date of Evaluation_	days per week for	weeks
Additional Visits # Requested	days per week for	weeks
Goals Updated Yes	No	
Mambar Activaly Participating	Eunstianal Progress Made	
ivieniber Actively Participating: _	Functional Progress Made	
Demonstrates Potential to Improv	ve	
zemonociaces i otendar to impro-	··	
Legality by signing below that wai	iting for a decision longer than 72 hours could place the member's lif	fe health or abilit
to gain maximum function in serio		c, ricaidi, or abili
_	Signature	
Submission of this form does not gua		