



# AUTHORIZATION REQUEST FORM

Please fill out this form completely and legibly. If you have questions or need assistance completing this request form, please call (800) 316-2273.

## CHOOSE THE APPROPRIATE REQUEST TYPE

Standard Request

Allow two (2) business days for review of prior authorization requests with receipt of clinical information and valid codes. If a response has not been received after two (2) business days, please contact Health Services to confirm that your request was received.

Priority Request

Please process ASAP as these services are scheduled on:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

Expedited Request

By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Additional Visits Request

Please review the following additional information to support our request for \_\_\_\_\_ additional visits on Authorization Number \_\_\_\_\_.

Signature Validating Expedited Request: \_\_\_\_\_ Date: \_\_\_\_\_

## MEMBER INFORMATION

Member Name: \_\_\_\_\_ Member ID: WX \_\_\_\_\_  
Reference/Authorization Number (if available): \_\_\_\_\_ Member DOB: \_\_\_\_\_

## PROVIDER INFORMATION

Ordering Physician: \_\_\_\_\_ Tax ID/NPI: \_\_\_\_\_  
First MI Last  
Person Completing Form: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
First Last  
Facility/Place of Service: \_\_\_\_\_ Tax ID/NPI: \_\_\_\_\_  
Facility Name or First MI Last  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## CLINICAL INFORMATION – Please fax any relevant clinical information for review.

<input type="radio"/> INPATIENT	<input type="radio"/> Observation <input type="radio"/> LTAC	<input type="radio"/> Medical <input type="radio"/> SNF/Swing/Sub-Acute	<input type="radio"/> Surgical	<input type="radio"/> Behavioral Health <input type="radio"/> Rehab
<input type="radio"/> OUTPATIENT	<input type="radio"/> Testing <input type="radio"/> Therapy—PT/OT/ST <small>Requires signed physician order</small>	<input type="radio"/> Radiology	<input type="radio"/> Surgery <input type="radio"/> Other Outpatient Rehab:	<input type="radio"/> Ambulance <small>Requires signed CMN</small> <input type="radio"/> Pharmacy-Part B

Dates of Service: \_\_\_\_\_ Qty of Days/Visits Requested: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_  
Service/Procedure(s): \_\_\_\_\_  
CPT-Procedure Code(s): \_\_\_\_\_

**Please attach/fax any relevant clinical information for review—including H&P, symptoms, diagnostics, labs, office notes, treatment plans, etc. Requests will be processed when all necessary information is received.**

## FAX this completed request and ALL supporting documentation to the applicable department fax.

Inpatient/LTAC: (615)782-7822 ♦ SNF/Rehab: (615)782-7868 ♦ Outpatient: (615)782-7842  
Behavioral Health: (615)782-7901 ♦ Pharmacy-Part B: (615)782-7869

If the determination is to deny a pre-service request, a letter noting the denial and appeal information will be mailed to the member and a copy will be faxed to the provider according to Medicare regulations.