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Please type this document to ensure accuracy and to expedite processing. All fields must be completed for the request to be processed. Please make a selection where applicable throughout the document.

DATE			
TYPE OF REQUEST	<input type="checkbox"/> URGENT	<input type="checkbox"/> STANDARD	<input type="checkbox"/> RETROSPECTIVE
TREATMENT SETTING	<input type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT	
REQUEST TYPE	<input type="checkbox"/> EXTENSION	<input type="checkbox"/> INITIAL	<input type="checkbox"/> CANCEL
<input type="checkbox"/> ADDITIONAL CLINICAL		<input type="checkbox"/> DISCHARGE PLANNING	
<input type="checkbox"/> TRANSPLANT EVALUATION NOTIFICATION (IN-NETWORK PROVIDERS ONLY)			
<input type="checkbox"/> TRANSPLANT LISTING (IN OR OUT OF NETWORK)			
<input type="checkbox"/> OTHER			
PREVIOUS AUTHORIZATION NUMBER			
CONTACT NAME			
CONTACT PHONE		CONTACT FAX	

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID		
MEMBER PHONE NUMBER		DATE OF BIRTH
MEMBER STREET ADDRESS		
CITY	STATE	ZIP



PROVIDER INFORMATION

PROVIDER NAME		
PROVIDER TIN	PROVIDER NPI	
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER	
PROVIDER STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <u> </u> PAR <u> </u> NON PAR <u> </u> IN CREDENTIALING		
FACILITY NAME		
FACILITY TIN	FACILITY NPI	
FACILITY PHONE NUMBER	FACILITY FAX NUMBER	
FACILITY STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <u> </u> PAR <u> </u> NON PAR <u> </u> IN CREDENTIALING		

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)		
REFERRING PHYSICIAN TIN		
REFERRING PHYSICIAN NPI		
REFERRING PHYSICIAN PHONE NUMBER		
REFERRING PHYSICIAN FAX NUMBER		
REFERRING PHYSICIAN STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <u> </u> PAR <u> </u> NON PAR <u> </u> IN CREDENTIALING		



MEDICAL SECTION

DIAGNOSIS CODE

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PROCEDURE CODE	START DATE	END DATE	NUMBER OF UNITS	CODE DESCRIPTION



MEDICAL SECTION

NOTES

PLEASE FAX TO **1-844-486-3290**
UTILIZATION MANAGEMENT DEPARTMENT PHONE: **1-833-533-8686**
TRANSPLANT UNIT FAX NUMBER: **1-844-796-1177**
TRANSPLANT UNIT DIRECT TOLL-FREE NUMBER: **1-833-983-7229**

PROVIDERS ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION FOR SERVICES PRIOR TO SCHEDULING. PLEASE SUBMIT CLINICAL INFORMATION, AS NEEDED, TO SUPPORT MEDICAL NECESSITY OF THE REQUEST. REQUESTS WILL NOT BE PROCESSED IF MISSING CLINICAL INFORMATION OR CPT AND ICD-10 CODES. AS A REMINDER, AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT; PAYMENT IS SUBJECT TO BENEFIT COVERAGE RULES, INCLUDING MEMBER ELIGIBILITY AND ANY CONTRACTUAL LIMITATIONS IN EFFECT AT THE TIME OF SERVICE.

URGENT MEDICAL CONDITION: ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.



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