

COMPLETE ALL INFORMATION

REVIEW TYPE Standard (≤ 14 days) Accommodate scheduling/patient needs (Date needed: _____)
 Check one
 Urgent (≤ 72 hours)
 Provider certifies that the standard review time frame would seriously jeopardize the member's life or health.
 Clinical reason for urgency: _____
 Practitioner signature: _____

DATE OF REQUEST _____

REQUEST TYPE - Check all that apply

Initial request Change to initial request - Auth #: _____ Addition to initial request - Auth #: _____
 Second medical opinion (Provide reason): _____
 Out-of-network provider request (Provide reason): _____

MEMBER ID#: _____ **MEMBER NAME (FIRST/LAST):** _____ **DOB:** _____

REQUESTING PROVIDER NAME (FIRST/LAST): _____

PROVIDER CONTACT NAME: _____ Phone: (____) _____ Ext. _____ Fax: (____) _____

PERFORMING/SERVICING PROVIDER: Check if same as Requesting Provider **NPI or TIN** _____
 Name (First/Last): _____ Specialty: _____
 Address: _____ Phone: (____) _____ Fax: (____) _____

FACILITY/SUPPLIER: Check if same as Requesting Provider **NPI or TIN** _____
 Name: _____
 Address: _____ Phone: (____) _____ Fax: (____) _____

Check applicable place of service below AND complete requested information.

COMPLETE APPLICABLE INFORMATION

PLACE OF SERVICE: Office (11) Home (12) Inpatient Hospital (21) Outpatient Hospital/Observation (22)
 Ambulatory Surgery Center (24) SNF (31) Other _____

REQUESTED DATES OF SERVICE: From: _____ To: _____

REQUESTED CPT/HCPCS CODE(S)	REQUESTED CPT/HCPCS CODE DESCRIPTION(S)	# VISITS/ DAYS/ UNITS REQUESTED	ICD CODE(S)	DIAGNOSIS (ICD CODE) DESCRIPTION(S)

DME: Bilateral Right Left / Purchase Rental / Initial Subsequent

**AUTHORIZATION DOES NOT GUARANTEE COVERAGE
AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT LIMITS OR PROVIDER CONTRACTUAL LIMITS.**

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LAST REVISED: 5/2018 – Apply updates to Y0089_MPINFO6651FH (05/18)