

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

		Date of Birth:		Member ID:	
Nursing Facility: _					
Ordering Provider	/Facility - Provide name,	address, phone #, f	ax #, and NPI #:		
SERVICES REQUE	STED (include copy of o		e for out-of-network request		
SNF Part A	☐ DME		☐ Home Health Care *Inc	• •	
☐ Inpatient Psych	Continued Sta	ay Review	Part B Drug	Specialist Visit	
Specialist Type:		Name:	Off	ice Phone:	
Primary Diagnosis	(ICD-10 Code # & Descri	ption):			
Diagnostic Testing	or Procedure (List Type,	CPT code w/descr	iption):		
Part B Drugs (List (CPT code, Dosage, Frequ	uency, Quantity):			
List Rendering Pro	vider:				
Rendering Provide	er Address:				
Start Date:	End Date:		Service:		
	er NPI #:				
	er NPI #:				
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This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond thoseauthorized or outside approval dates will be subject to denial of payment.