



Inpatient/Outpatient Services Prior Authorization Request Form

To request services for Medicare Advantage fax to 1-888-535-5243.

Requests can be submitted online at any time through **Availity.com**.

Inpatient Outpatient

Please indicate if service request meets CMS/NCQA definition of Urgent or Expedited: Yes, Urgent/Expedited

Rationale: _____

Submitter Contact Information

Name: _____

Phone: _____ Fax: _____

Member Information

Member Name: _____

Member ID Number: _____ Member Gender: _____

Member Address: _____

Member Phone Number: _____ Date of Birth: ____/____/____

Primary Diagnosis for requested service, (list ICD-10 Codes):

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Ordering Physician

Ordering Physician: _____

Provider Number: _____

Phone Number: _____ Fax Number: _____

National Provider Identifier: _____ Tax ID: _____

Address: _____

Treating Facility Information

Treating/Facility Name: _____

Provider Number: _____

Phone Number: _____ Fax Number: _____

National Provider Identifier: _____ Tax ID: _____

Address: _____

Service Type (Select appropriate service type)

Date of Service/Admit Date: ____/____/____

Type of admit: Emergency or Elective (scheduled): _____

If extension, What are the dates of service requested? _____

Please include applicable procedure(s) names and code(s) below.

Name/Description	CPT®/HCPCS

Please include specific clinical supporting the medical necessity of the requested items.

Clinical Information

Past medical history, provider's orders/treatment plan, IV meds, oxygen support, all pertinent lab values, all pertinent diagnostic testing, wound description and care, nutrition/diet, activity, prior level of function, therapy notes/evaluation, discharge plans and any other supportive information. Please attach imaging reports if applicable.

Disclaimer: Authorization is not a confirmation of coverage or benefits. Benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered.