1. **Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: | Last Name: | Member Date of Birth:// | Health Plan ID: |

1. **Provider Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Ordering/Servicing Provider Name:** | NPI:  | Specialty: | **Ordering Network Status:** |
|  | TIN:  |  |  |
| **Servicing Facility Name**:  | NPI:  | **Facility Network Status:** |

1. **Requested Services/Referral**

|  |  |
| --- | --- |
| **Diagnosis Code(s) (ICD-10):** | **Diagnosis Code(s) Description(s):** |
|  | # Days Requested  | Reason: |
|  | # Days Requested  | G Code: |  |
| **Place of Service:** |  |

|  |  |
| --- | --- |
|  |  **Date Requested Services Anticipated to be Performed (MM/DD/YY**): // |
| **HCPCS/CPT/CDT/Rev Codes:** | **Code Description:**  | **Frequency:** | **HCPCS/CPT/CDT/Rev Codes:** | **Code Description:**  | **Frequency:** |
|   |  |  |   |  |  |
|   |  |  |   |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | DME Supplier Name:  | DME Type:  |
|  | (If Outside Provider List name):  |
|  |  | Specialist Name: | Appointment Date (If Known): // |

1. **Therapy Requests**

|  |
| --- |
| **Requested Therapy Services:**  **Reason for Therapy Request:**  |
| **Therapy Request Type**:     |
| # Therapy Days Requested:  # Days Per Week:  For How Many Weeks:  |

**TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION:**

|  |  |
| --- | --- |
|  | CMS allows 14 days for standard authorizations. Our goal is 3-5 days. To promote more expedient turnaround times, please ensure all supporting documentation is provided at the time of the request. |
|  | **Expedited Authorization (MUST READ & SIGN FOR ALL EXPEDITED REQUESTS**): By signing below I certify that waiting for a decision under the standard time frame could place the Member’s life, health, or ability to gain maximum function in serious jeopardy.**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Name of Person Completing this Form: Date Completed:**// **Phone #: FAX:**

