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:**

