REQUEST FOR AUTHORIZATION

Prior Authorization Department
Phone: (800) 322-6027 # 2, then press (3)
Fax: (866) 946-2052

PRIOR AUTHORIZATION MUST BE OBTAINED PRIOR TO THE DAY OF PROCEDURE

Date of Request: ____

Contact Person Name: ____

Phone Number: ____

Fax Number You Want This Request Faxed Back to: _____________________________

Inpatient Surgery   Observation   Outpatient Procedure/Testing/Surgery
(Please Circle One)

Member Name: ____

Member DCN: ______________________________DOB: ____________________________

Facility where Procedure will be performed: ____________________________________

Ordering Physician: ____

Date of Procedure: ____

ICD-9 Code: ____

Test/Procedure Requested: ____

CPT Code: ____

Please attach clinical information to support medical necessity of requests for authorization. Requests *will not* be processed without clinical.

- CPT codes and clinical information to support medical necessity are vital to ensure authorization is complete for appropriate claim processing and payment.
- All procedures and testing are reviewed against Milliman Criteria.
- Requests that do not meet criteria are referred to our medical director for review. Clinical information must be provided to support medical necessity.
- Authorizations cannot be back dated

AUTHORIZATION NUMBER: ____

Updated 10-30-08