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Authorization Request Form

Date_____ **No. of Pages**_____ ☐ **Standard Request** ☐ **Expedited Request**

Member Information	
Member ID:	
Member's Name: Last Name, First Name	
Date of Birth:	
Member's Street Address	
City/State/Zip	
Member's Tel #	

Requesting Provider Information	
Provider Name	
NPI #:	
Tax ID #:	
Service Address:	
City/State/Zip	
Tel /Fax	

Check the assignment category below:

Network: ☐ **In-Network** ☐ **Out-of-Network**

Service Type:

☐ **Inpatient Facility Stay (Hospital/SNF/Others)**

☐ **Outpatient Service** _____

☐ **Home Care Service**_____

☐ **Ambulatory Surgery**_____

☐ **DME/Supplies**

Servicing Provider Information	
Provider Name	
NPI #:	
Tax ID #:	
Service Address:	
City/State/Zip	
Tel /Fax	

Place of Service: ☐ **Facility** ☐ **Office** ☐**Member's Home** ☐ **Others** _____

Clinical Information				
Dates of Service		Dx. ICD-10	CPT / HCPCS:	Visits / Frequency or # of units
Start	End			

- Please complete this form for all **initial** and **concurrent** requests.
- Ensure that all **appropriate clinical documentation** is attached to support the request.
- For questions, please contact us at **1-800-353-3765**

Please attach all supporting clinical documentation with this form. Thank you.

MJHS