PRIOR AUTHORIZATION
Secure Fax (281) 809-6760

PROVIDER INFORMATION

Date: ____________________**Requestor First Name & Last Initial:** ____

Call Back Number: ____**EXT or Option:** _____________________________

With Practice/Facility Name: ____

Phone Number: _______________________________________ **Fax Number**: _________________________________

PATIENT INFORMATION

Patient Name: ____ **Date of Birth:** __________________________

Member ID Number: ________________________________ **OTHER ID#:** ______________________________________

AUTHORIZATION INFORMATION

Service Type: ☐ Inpatient ☐ Outpatient* **Admission Type**: ☐ Emergent ☐ Direct ☐ Scheduled

***Outpatient Authorization is based on the patient's plan and clinical documentation may be required**
OP Observation greater than 23 hours requires authorization
ALL IP ADMISSIONS REQUIRE CLINICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY & LENGTH OF STAY

Diagnosis [code(s) & description(s)]: ____

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Procedure [code(s) & description(s)]: ____

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Ordering/Admitting MD: ____**NPI**__________________________

FACILITY/Site of Service: ____**TIN**_________________________

IF IP: UR Phone Number: _________________________________ **UR Fax Number:** ____________________________

Scheduled/Admission Date: _____________________If Applicable/Available **DISCHARGE DATE:** ________________

NOTES:

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FAX REQUEST AND CLINICAL DOCUMENTATION TO 281-809-6760

Disclaimer: Authorizations are confirmation of medical necessity only and not a guarantee of payment. Claims are subject to eligibility, all plan provisions and post-claim evaluation.

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