Medical Helpline

PRIOR AUTHORIZATION

FAX REQUEST AND CLINICAL DOCUMENTATION TO SECURE FAX 281-809-6760

(Must verify benefits and eligibility prior to submission. Incomplete forms cannot be processed)

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#:** _____

INTER OFFICE USE ☐ MEC ☐ CIGNA ☐ RBP ☐ COBRA ☐ Patient Eligible ☐ CM

AUTHORIZATION INFORMATION

Service Type: ☐ Inpatient ☐ Outpatient † ☐ Provider Administered Medication

Procedure/Admission Type: ☐ Emergent ☐ Direct ☐ Scheduled

† Outpatient Authorization is based on the patient's plan and clinical documentation may be required

Outpatient Observation greater than 23 hours REQUIRES authorization

ALL IP ADMISSIONS REQUIRE CLINICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY & LENGTH OF STAY

Diagnosis code(s): * _____

Procedure code(s): * _____

_____

Dosage, Frequency & Route (cycles if chemo): * _____

_____

Initial Treatment? * ☐ Yes ☐ No **Continued Tx?** * **Last DOS:** _____ **Next DOS:** _____

Ordering/Admitting MD * _____ **NPI** * _____

Phone * _____ **Fax** * _____ **TIN** * _____

Address * _____ **City** * _____ **State** * _____ **Zip** * _____

FACILITY/Site of Service * _____ **NPI** * _____

Phone * _____ **Fax** * _____ **TIN** * _____

Address * _____ **City** * _____ **State** * _____ **Zip** * _____

IF IP: UR Phone Number: _____ **UR Fax Number:** _____

Scheduled/Admission Date: _____ ☐ **TBD** **DISCHARGED:** ☐ **Yes** ☐ **No** **DATE** _____

NOTES: _____

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.

* Indicates a required field

90 DEGREE BENEFITS
A Turn For The Better