

**\*\*USE THIS FORM TO REQUEST SERVICES SPECIFIC FOR BEHAVIORAL HEALTH OR DEVELOPMENTAL DISABILITY PROVIDERS**

Requestor's Contact Name: \_\_\_\_\_ Requestor's Contact #: \_\_\_\_\_

**Patient Information:**

\*Name: \_\_\_\_\_ \*DOB: \_\_\_\_\_

\*Patient ID #: \_\_\_\_\_ \*Patient Phone #: \_\_\_\_\_

\*Service Is:  Elective / Routine  Expedited / Urgent

**Note:** Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-855-429-1028)

**\*Service Type Requested:** Please review plans benefit prior to request

Behavioral Health	Intellectual/Developmental Disability	Other
<input type="checkbox"/> Acute <input type="checkbox"/> Psychiatric residential treatment <input type="checkbox"/> Outpatient behavioral health <input type="checkbox"/> Concurrent Review <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/> ICF <input type="checkbox"/> Outpatient <input type="checkbox"/> Other	

**Procedure Information:**

\*ICD 10 Diagnosis: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

\*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies): \_\_\_\_\_

\*Date(s) of Service: \_\_\_\_\_ # of Units or Visits: \_\_\_\_\_

**Provider Information:**

**Requesting Provider** Is this the patient's Primary Care Physician?  Yes  No

\*Name: \_\_\_\_\_ \*NPI \_\_\_\_\_ TIN: \_\_\_\_\_

\*Phone: \_\_\_\_\_ \*Fax \_\_\_\_\_

\*Address: \_\_\_\_\_

**Rendering Provider**  Same as the Requesting Provider

**If Requesting and Rendering providers differ, complete section below**

\*Name: \_\_\_\_\_ \*NPI \_\_\_\_\_ \*TIN: \_\_\_\_\_

\*Phone: \_\_\_\_\_ \*Fax \_\_\_\_\_

\*Address: \_\_\_\_\_

**Facility**  N/A

\*Name: \_\_\_\_\_ \*NPI \_\_\_\_\_ \*TIN: \_\_\_\_\_

\*Phone: \_\_\_\_\_ \*Fax \_\_\_\_\_

\*Address: \_\_\_\_\_

**Request for extension to existing authorization number:**

**PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.**

**Always verify eligibility, benefits and prior authorization requirements**

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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