



Authorization Request Form Attn:  
Intake Processing Unit  
Phone: 1-844-857-1601  
Fax: 1-800-413-8347

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

Authorization Type: (check one) \_\_\_\_\_ Standard \_\_\_\_\_ Urgent / Expedited

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Check here if request is in response to a denied claim \_\_\_\_\_

Member Name: \_\_\_\_\_

Member Number: **AR** \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Prescribing Provider: \_\_\_\_\_

Servicing Provider/Facility Name: \_\_\_\_\_

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

**Request Service: Inpatient Admissions Service Dates:** \_\_\_\_\_

\_\_\_\_\_ Acute Inpatient Hospital Admission \_\_\_\_\_ Psychiatric Inpatient Admission

\_\_\_\_\_ Skilled Nursing Admission \_\_\_\_\_ Inpatient Rehab Admission

**Request Service: Outpatient Services Service Dates:** \_\_\_\_\_

\_\_\_\_\_ Physical Therapy \_\_\_\_\_ Durable Medical Equipment

\_\_\_\_\_ Occupational Therapy \_\_\_\_\_ Ambulatory / Outpatient Surgery

\_\_\_\_\_ Speech Therapy \_\_\_\_\_ Home Health

\_\_\_\_\_ Diagnostic Services \_\_\_\_\_ Radiology Services

\_\_\_\_\_ **Out of Network Inpatient or Outpatient Services**

ICD \_\_\_\_\_ Diagnosis Descriptions \_\_\_\_\_

Service Code (CPT, HCPCS, etc.) \_\_\_\_\_ Service Descr. \_\_\_\_\_

Quantity/Frequency/Duration (as applicable): \_\_\_\_\_

\_\_\_\_\_ **Clinicals are attached to support request. (All applicable clinicals should be attached.)**

For Questions Regarding this Request, Contact:

Name: \_\_\_\_\_

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

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