Superior Select Health Plans

**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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