

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.

EXPEDITE REQUEST: By checking this box, I am stating that waiting for a decision under the standard CMS time frame (14 days) could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy

Member Name: _____

Member Number: **AR** _____ Date of Birth: ____ / ____ / _____

Requesting Provider: _____

Servicing Provider: _____

Contact Name: _____

Contact Phone: _____ Contact Fax: _____

Requested Service:

- | | |
|--|--|
| <input type="checkbox"/> Inpatient Hospital Admission | <input type="checkbox"/> Durable Medical Equipment / Prosthetics |
| <input type="checkbox"/> Psychiatric Inpatient Admission | <input type="checkbox"/> Mental Health Specialty Services† |
| <input type="checkbox"/> Skilled Nursing Admission† | <input type="checkbox"/> Home Health* |
| <input type="checkbox"/> Partial Hospitalization | <input type="checkbox"/> Psychiatric Services† |
| <input type="checkbox"/> Physical Therapy† | <input type="checkbox"/> Out of Network Services |
| <input type="checkbox"/> Occupational Therapy† | |
| <input type="checkbox"/> Speech Therapy† | |

Service Dates: _____

ICD: _____ Dx Description: _____

Service Code 1 _____ Service Code 1 _____

(HCPCS, CPT, etc.): _____ Description: _____

Service Code 2 _____ Service Code 2 _____

Description: _____

Quantity / Frequency / Duration (as applicable): _____

All supporting information must be supplied with clinical documentation attached before a consideration will be made.

*Referral from a contracted provider is required in addition to prior authorization.

†Authorization not required for facilities under alternative payment / value based / bundled payment arrangements.