

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

Requesting Provider NPI#: \_\_\_\_\_ Requesting Provider Tax ID#: \_\_\_\_\_

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

Servicing Provider NPI#: \_\_\_\_\_ Servicing Provider Tax ID#: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_ Contact Fax: \_\_\_\_\_

**Requested Service:**

- |  |   |
|--|---|
| <input type="checkbox"/> Inpatient Hospital Admission                                  | <input type="checkbox"/> Durable Medical                  |
| <input type="checkbox"/> Psychiatric Inpatient Admission                               | Equipment/Prosthetics                                     |
| <input type="checkbox"/> Skilled Nursing Admission                                     | <input type="checkbox"/> Mental Health Specialty Services |
| <input type="checkbox"/> Partial Hospitalization                                       | <input type="checkbox"/> Home Health*                     |
| <input type="checkbox"/> Physical Therapy  | <input type="checkbox"/> Psychiatric Services             |
| <input type="checkbox"/> Occupational Therapy  | <input type="checkbox"/> Out of Network Services          |
| <input type="checkbox"/> Speech Therapy  |   |
| <input type="checkbox"/> Medicare Part B Drugs (Antibody and Gene/Cell Therapies only) |   |

*No auth needed for Medicare-covered Outpatient Hospital Services, Observation Services, Lab Services and Diagnostic Procedures/Tests.*

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): \_\_\_\_\_

**Clinicals are attached to support this case**

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