



AUTHORIZATION REQUEST FORM

Please fill out this form completely and legibly. If you have questions or need assistance completing this request form, please call (888)904-8387.

Underwritten by Sterling Life Insurance Company

CHOOSE THE APPROPRIATE REQUEST TYPE

Standard Request

Allow two (2) business days for review of prior authorization requests with receipt of clinical information and valid codes. If a response has not been received after two (2) business days, please contact Health Services to confirm that your request was received.

Expedited Request

By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Signature Validating Expedited Request: _____ Date: _____

Priority Request

Please process ASAP as these services are scheduled on:

_____/_____/_____
Month Day Year

Additional Visits Request

Please review the following additional information to support our request for _____ additional visits on Authorization Number _____.

MEMBER INFORMATION

Member Name: _____ Member ID: _____

Reference/Authorization Number (if available): _____ Member DOB: _____

PROVIDER INFORMATION

Ordering Physician: _____
First MI Last Tax ID/NPI: _____

Person Completing Form: _____ Phone: _____ Fax: _____
First Last

Facility/Place of Service: _____ Tax ID: _____
NPI: _____
Facility Name or First MI Last

Address: _____

Phone: _____ Fax: _____

CLINICAL INFORMATION – Please fax any relevant clinical information for review.

<input type="radio"/> INPATIENT	<input type="radio"/> Observation <input type="radio"/> LTAC	<input type="radio"/> Medical <input type="radio"/> SNF/Swing/Sub-Acute	<input type="radio"/> Surgical	<input type="radio"/> Behavioral Health <input type="radio"/> Rehab
<input type="radio"/> OUTPATIENT	<input type="radio"/> Testing <input type="radio"/> Therapy—PT/OT/ST extension <i>Requires signed physician order</i>	<input type="radio"/> Radiology	<input type="radio"/> Surgery <input type="radio"/> Pharmacy-Part B	<input type="radio"/> Behavioral Health <input type="radio"/> Ambulance <i>Requires signed CMN</i>

Dates of Service: _____ Qty of Days/Visits Requested: _____

Diagnosis: _____ ICD-9 Code: _____

Service/Procedure(s): _____

CPT-Procedure Code(s): _____

Please attach/fax any relevant clinical information for review--including H&P, symptoms, diagnostics, labs, office notes, treatment plans, etc. Requests will be processed when all necessary information is received.

FAX this completed request and ALL supporting documentation to the applicable department fax.

Inpatient/LTAC: 866-790-2405 ♦ SNF/Rehab: 866-790-2406 ♦ Outpatient: 866-790-2465 ♦ Behavioral Health: 866-790-4014

If the determination is to deny a pre-service request, a letter noting the denial and appeal information will be mailed to the member and a copy will be faxed to the provider according to Medicare regulations.