HealthFirst

Health Plans

Medical Authorization Request Form

Fax form to 1.855.328.0059 / Phone: 1.800.716.7737 TDD: 1.800.955.8771/ hf.org/healthplans

Please complete all information below.

REVIEW TYPE – *Check one*

- ❑ **Standard (≤ 14 days)**
- ❑ **Accommodate scheduling/patient needs** (Date needed: __/__/__)
- ❑ Urgent (≤ 72 hours)

  Provider certifies that the standard review time frame would seriously jeopardize the member's life or health.

  Clinical reason for urgency: ____

  ____

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DATE OF REQUEST __/__/__

REQUEST TYPE – Check all that apply

- ❑ Initial request
- ❑ Change to initial request – Auth #: __________________
- ❑ Addition to initial request – Auth #: __________________
- ❑ Second medical opinion (Provide reason): ____
- ❑ Out-of-network provider request (Provide reason): __________________________________

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Member ID#: _____________________ **DOB:** __/__/__

Member Name (First/Last): ________________________________

Requesting Provider Name (First/Last): ______________________

Provider Contact Name: ____

Provider Phone: (___)___-_____Ext._____ **Fax:**(___)___-_____

Performing/Servicing Provider:

NPI or TIN _______________

Name (First/Last): ____

Specialty: ____________________________________

Address: ____

Phone: (___) ___-____ **Fax:** (___) ___ - ____

Facility/Supplier:

NPI or TIN ______________

Name: ____

Address: ______________________________________

Phone: (___) ___-____ **Fax:** (___) ___-____

Place of Service:

❑Office (11) ❑Home (12) ❑Inpatient Hospital (21) ❑Outpatient Hospital/Observation (22)

❑Ambulatory Surgery Center (24) ❑SNF (31) ❑Other ______________________

Requested Dates of Service: From: __/__/__ To: __/__/__

CPT/HCPCS Code(s)	Code Description	# Units/Days Requested	ICD Code(s)	ICD Description
DME: ❑ Bilateral ❑ Right ❑ Left ❑ Purchase ❑ Rental ❑ Initial ❑ Subsequent				

AUTHORIZATION DOES NOT GUARANTEE COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT LIMITS OR PROVIDER CONTRACTUAL LIMITS.

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