



Highmark Blue Shield
Clinical Services Utilization Management
Authorization Request Form

Submission Instructions: Only One Patient Per Fax. Please print all information.
IMPORTANT! LIMIT FAXED INFORMATION TO JUST RELEVANT CLINICAL INFORMATION THAT SUPPORTS MEDICAL NECESSITY FOR THE REQUEST. A REVIEW **CANNOT** BE PROCESSED WITHOUT IT– Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.
 Please fax completed form to Clinical Services: **OUTPATIENT: 888.236.6321 or 800.670.4862 (Delaware)**
INPATIENT: 800.416.9195 or 877.650.6069 (Delaware)

Is this a request for an out of network gap exception?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Patient Name:			
Patient Date of Birth (mm/dd/yyyy):			
Patient ID/UMI Number (with Prefix):			
Name of Requestor/Contact Person:			
Requesting Provider Name:			
Requesting Provider NPI:		Requesting Provider BSID:	
Requesting Provider Address			
Street:			
City:			
State:		Zip Code:	
Requestor's Phone Number:			
Requestor's Fax Back Number:			
Primary Diagnosis Code(s):			
Primary Diagnosis Description(s):			
Procedure/Service CPT Codes(s)			
Type of Service Requested: (Please designate Inpatient Planned or Outpatient Planned for elective surgical procedures)	<input type="checkbox"/> Inpatient Planned (Elective)	<input type="checkbox"/> Inpatient Urgent - Initial	<input type="checkbox"/> Home Health
	<input type="checkbox"/> Inpatient Planned – Continued Stay	<input type="checkbox"/> Inpatient Urgent - Continued Stay	<input type="checkbox"/> Durable Medical Equipment (DME)
	<input type="checkbox"/> Skilled Nursing Facility Transfer	<input type="checkbox"/> Outpatient Planned Surgery	<input type="checkbox"/> Physical Therapy
	<input type="checkbox"/> Inpatient Rehab Facility Transfer	<input type="checkbox"/> Other Ancillary service/procedure	<input type="checkbox"/> Occupational Therapy
	<input type="checkbox"/> LTAC Transfer	<input type="checkbox"/> Hospice	<input type="checkbox"/> Speech Therapy
	<input type="checkbox"/> Elective	<input type="checkbox"/> Urgent / Emergent	<input type="checkbox"/> Non-Urgent
Type of Admission/Request:			
Inpatient Admission Date or Start of Care Date (mm/dd/yyyy):			
Number of requested visits / units (If applicable):			
Facility Name:			
Facility NPI:		Facility BSID:	
Facility Address:			
Street:			
City:			
State:		Zip Code:	
Admitting/Service Provider's Name:			
Admitting/Service Provider's NPI:		Admitting / Service Provider BSID:	
Admitting/Service Provider's Address:			
Street:			
City:			
State:		Zip Code:	

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