



# Authorization Request

Please Fax All Requests to: 866-293-9665

Non-Urgent (minimum 7 days notice)  Urgent (minimum 2 days notice)

Today's Date: \_\_\_\_\_

**ALL CLINICAL DOCUMENTATION MUST BE ATTACHED TO AVOID PROCESSING DELAYS**  
**ALL CLINICAL NOTES AND/OR ORDERS ONLY ACCEPTED FROM MD, NP/FNP, PA-C or APRN**

### MEMBER INFORMATION (\*Denotes required field)

\*Patient Name: \_\_\_\_\_ \*Date of Birth: \_\_\_\_\_ \*Gender:  Female  Male

\*Member ID#: \_\_\_\_\_ \*Primary Insurance: \_\_\_\_\_ Other Insurance: (TPL, Worker's Comp): \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date & Place of Injury (if applicable): \_\_\_\_\_

### PROVIDER INFORMATION (\*Denotes required field)

\*Referring Provider Name: \_\_\_\_\_ \*Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*NPI#: \_\_\_\_\_ \*Tax ID#: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*Servicing/Treating Facility/Provider:  Same as Requesting \*Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*NPI#: \_\_\_\_\_ \*Tax ID#: \_\_\_\_\_

\*Address: \_\_\_\_\_

### SERVICE TYPE REQUIRING AUTHORIZATION (Check all that apply)

<b>Ambulatory/Outpatient Services/Office</b> <input type="checkbox"/> Surgery/Procedure <input type="checkbox"/> Infusion or Oncology Drugs <input type="checkbox"/> Chemo <input type="checkbox"/> Dialysis <input type="checkbox"/> Injections	<b>Equipment/Supplies</b> <input type="checkbox"/> Renal Supplies <input type="checkbox"/> CPAP <input type="checkbox"/> Oxygen <input type="checkbox"/> Prosthetic Device <input type="checkbox"/> Purchase / Rental <input type="checkbox"/> Purchase/Rental Price \$ _____	<b>Home Services</b> <input type="checkbox"/> SN <input type="checkbox"/> ST <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Hospice <input type="checkbox"/> Respite Care <input type="checkbox"/> Infusion Therapy
<b>Inpatient Care/Observation</b> <input type="checkbox"/> Acute Medical/Surgical <input type="checkbox"/> Long Term Acute Care <input type="checkbox"/> Acute Rehab <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Observation <input type="checkbox"/> Transplant	<b>Radiology/Laboratory</b> <input type="checkbox"/> Mammogram <input type="checkbox"/> CT/CTA <input type="checkbox"/> Pet Scan <input type="checkbox"/> MRI/MRA <input type="checkbox"/> Lab <input type="checkbox"/> Ultrasound	<b>Outpatient/Therapy</b> <input type="checkbox"/> SN <input type="checkbox"/> ST <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Pulmonary/Cardiac Rehab

Other-please specify: \_\_\_\_\_

Place of Service (choose one):  Office  Inpatient Hospital  Outpatient Hospital  Ambulatory Surgical Center  Other

### DIAGNOSIS/PLANNED PROCEDURE INFORMATION (\*Denotes required field)

\*Services Requested (Description & CPT/HCPCS/J-Code(s)): \_\_\_\_\_

\*Principal Diagnosis (Description & ICD-10 Code(s)): \_\_\_\_\_

Units/Type Requested: \_\_\_\_\_  
# of Units                      Service Type (hours,days, visits, dosage)

\*Service Start Date: \_\_\_\_\_ \*Service End Date: \_\_\_\_\_

### CONTACT PERSON/REVIEW REQUIRED DOCUMENTATION ATTACHED (\*Denotes required field)

\*Contact Person/Title: \_\_\_\_\_ \*Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ \*Tax ID#: \_\_\_\_\_

### Clinicals and Provider Order or Provider Signature required to accept authorization request for review.

\*Are Clinicals Attached?  Yes  No                      Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Is Order Attached?  Yes  No

**PLEASE NOTE: ALL ABOVE SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL IN ORDER FOR REQUEST FOR AUTHORIZATION TO BE ACCEPTED FOR REVIEW. INCOMPLETE SUBMISSIONS WILL BE RETURNED.**

Authorization is based on the medical appropriateness of the services requested and should not be a guarantee of coverage or payment. Actual benefit payment is contingent upon eligibility, benefits available at the time service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, as well as other provisions of the medical plan.

The information contained in this form, including attachments, is privileged and confidential, and is only for the use of the individuals or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible for delivering it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify the sender immediately and shall destroy all information received.

Authorization Requests for Cigna Network please contact (800) 448-3585 in order to obtain an Authorization approval.  
Authorization Requests utilizing all other networks - please complete form in its entirety and fax to (866) 293-9665.