Authorization Request

Please send all requests to **866-293-9665**

☐ **Non-Urgent** (Minimum 7 Days Notice) ☐ **Urgent** (Minimum 2 Days Notice) **Today's Date:** ______________

Please Note: All clinical documentation must be attached to avoid processing delays. All clinical notes and/or orders only accepted from an MD, DO, NP/FNP, PA-C, APRN, DC, or ND (dependent and according to state licensing requirements).

Member Information (*Denotes Required Field)		
*Patient Name:	*Date of Birth:	*Gender: ☐ Male ☐ Female
*Member ID:	*Primary Insurance:	Other Insurance: (TPL, Worker's Comp)
Address:		Phone Number:
Date & Place of Injury (If applicable):		

Provider Information		
*Referring Provider Name:	*Phone:	Fax:
*NPI Number:	*Tax ID Number:	
Address:		

Servicing/Treating Facility		
*Servicing/Treating Facility:	*Phone:	Fax:
*NPI Number:	*Tax ID Number:	
Address:		

Service Type Requiring Authorization
Place of Service: (Choose One) ☐ Office ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Ambulatory Surgical Center
Other: (Please Specify)

Diagnosis/Planned Procedure Information		
***Services Requested (Description & CPT/HCPCS/J-Code(s):**	***Principal Diagnosis (Description & ICD-10 Code(s)):**	
	Units/Type Requested: Number of Units: Service Type *(Hours, Days, Visits, Dosage)*:	
***Scheduled Service Date:**	***Scheduled Service End Date:**	
***Contact Person:**	***Phone:**	**Fax:**

Clinicals and Provider Order or Provider Signature required to accept authorization request for review	
***Are Clinicals Attached?** ☐ **Yes**	***Is Order Attached?** ☐ **Yes**
MD Signature	**Date:**

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.