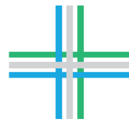

REQUEST FOR MEDICAL NECESSITY DETERMINATION

FAX REQUEST AND CLINICAL DOCUMENTATION TO SECURE FAX 281-809-6760

(Must verify benefits and eligibility prior to submission. Incomplete forms cannot be processed)

PROVIDER INFORMATION

Date: * ______________________ **Requestor First Name & Last Initial:** * ______________________

Call Back Number: * ______________________ **EXT or Option:** * ______________________

With Practice/Facility Name: * ______________________

Phone Number: * ______________________ **Fax Number:** * ______________________

PATIENT INFORMATION

Patient: * ______________________ **Member ID #:** * ______________________

DOB: * ____________ **Other Insurance Coverage (OIC):** ☐ Y ☐ N **OIC Carrier:** ______________________

OIC Group #/Name: ______________________ **OIC Policy #:** ______________________ **Is OIC Primary?** ☐ Y ☐ N

INTER OFFICE USE ☐ MEC ☐ CIGNA ☐ RBP ☐ COBRA ☐ Patient Eligible ☐ CM

AUTHORIZATION INFORMATION

Service Type: ☐ Inpatient ☐ Outpatient † ☐ Provider Administered Medication

Procedure/Admission Type: ☐ Emergent ☐ Direct ☐ Scheduled

† Outpatient Authorization is based on the patient's plan and clinical documentation may be required

Outpatient Observation greater than 23 hours REQUIRES authorization.

ALL IP ADMISSIONS REQUIRE CLINICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY & LENGTH OF STAY

Diagnosis code(s): * ______________________

Procedure code(s): * ______________________

____

Dosage, Frequency, Route & Units (cycles if chemo): * ______________________

____

Initial Treatment? * ☐ Yes ☐ No **Continued Tx?** * **Last DOS:** ____________ **Next DOS:** ____________

DME: ☐ **Purchase Cost:** ____________ ☐ **Rental (Start:** ________ **End:** ________ **) Cost:** ____________

Ordering/Admitting MD * ______________________ **NPI** * ____________

Phone * ______________________ **Fax** * ______________________ **TIN** * ____________

Address * ______________________ **City** * ______________________ **State** * ______ **Zip** * ______

FACILITY/Site of Service * ______________________ **NPI** * ____________

Phone * ______________________ **Fax** * ______________________ **TIN** * ____________

Address * ______________________ **City** * ______________________ **State** * ______ **Zip** * ______

IF IP: UR Phone Number: ______________________ **UR Fax Number:** ______________________

Scheduled/Admission Date: ______________________ ☐ **TBD** **DISCHARGED:** ☐ **Yes** ☐ **No** **DATE** ____________

NOTES: ______________________

Disclaimer: Authorizations are confirmation of medical necessity only and not a guarantee of payment. Claims are subject to eligibility, all plan provisions and post-claim evaluation.

* Indicates a required field

Rev. 20230823

CONFIDENTIAL