



General Fax Authorization Request
Medical Management
Fax 1-800-241-5308

Member/Subscriber Information: ID No.: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Patient Information: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to Member/Subscriber: [ ] Self [ ] Spouse [ ] Child DOB: \_\_\_\_\_ Sex: [ ] M [ ] F

Separate Insurance:

Is this service related to: [ ] a motor vehicle accident? [ ] Worker's Compensation? (check one)

Is there any other insurance? [ ] Yes [ ] No

If yes, name of other insurance carrier: \_\_\_\_\_

Is the other insurance primary? [ ] Yes [ ] No

Authorization requested for: (check one service per fax form) [ ] Emergency [ ] Scheduled

- [ ] Inpatient Acute [ ] Air Ambulance
[ ] Ambulatory Surgery [ ] Radiology Services ( [ ] MRI [ ] MRA [ ] CT Scan
[ ] Inpatient Rehabilitation [ ] PET Scan [ ] Nuclear Cardiology)
[ ] Skilled Nursing Facility [ ] Outpatient Therapy ( [ ] PT [ ] OT [ ] ST [ ] Vision)
[ ] Hospice [ ] Cardiac Rehab [ ] Homecare [ ] Home Infusion
[ ] Referral to Nonparticipating Provider

•Admission date: \_\_\_\_\_ •First date of service: \_\_\_\_\_ No. visits requested: \_\_\_\_\_
•Requested length of stay (days): \_\_\_\_\_ •Authorization period requested (days): \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD9 CODE: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ ICD9 CODE: \_\_\_\_\_

Procedure: CPT4 Code: \_\_\_\_\_ CPT4 CODE: \_\_\_\_\_

Facility/Provider Information: Name: \_\_\_\_\_

Physician Information:

Name of ordering physician: \_\_\_\_\_ Provider No.: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_
(area code) (area code)

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

Fax request submitted by: Name: \_\_\_\_\_

FOR EMPIRE USE

Authorization Status:

Approved: [ ] Yes LOS Authorized: \_\_\_\_\_ OR No. of visits \_\_\_\_\_ for period of \_\_\_\_\_ days authorized

Authorization No.: \_\_\_\_\_ \*Date authorization completed: \_\_\_\_\_

Denied: [ ] Yes By: \_\_\_\_\_ Phone No.: \_\_\_\_\_
(area code)

Pended: For Additional medical information \_\_\_\_\_ For medical review \_\_\_\_\_

Comments: \_\_\_\_\_

\* This authorization is based upon medical necessity, subject to the terms and conditions of the member's contract and is NOT a guarantee of payment.