Health Plans

Medical Authorization Request Form

Fax medical authorization requests to: 1.855.328.0059
Phone: Toll-Free 1.800.716.7737 /TDD Relay 1.800.955.8771
Visit myHFHP.org

Complete all information in this section

REVIEW TYPE – *Check one*

- ❑ **Standard (≤ 14 days)**
- ❑ **Accommodate scheduling/patient needs** (Date needed: ______/______/______)
- ❑ Urgent (≤ 72 hours)
  Provider certifies that the standard review time frame would seriously jeopardize the member's life or health.
  Clinical reason for urgency: ____________________
  Practitioner signature: ____________________

DATE OF REQUEST ______/______/______

REQUEST TYPE – Check all that apply

- ❑ Initial request ❑ Change to initial request – Auth #: ____________________
- ❑ Addition to initial request – Auth #: ____________________
- ❑ Second medical opinion (Provide reason): ____________________
- ❑ Out-of-network provider request (Provide reason): ____________________

Member ID#: ____________________ **DOB:** ______/______/______

Member Name (First/Last): ____________________

Requesting Provider Name (First/Last): ____________________

Provider Contact Name: ____________________

Provider Phone: (______)____________________Ext.________ Fax: (______) ____________________

Performing/Servicing Provider: ❑ Check if same as Requesting Provider **NPI or TIN** ____________

Name (First/Last): ____________________ Specialty: ____________________

Address: ____________________

Phone: (______)____________________ Fax: (______)____________________

Facility/Supplier: ❑ Check if same as Requesting Provider **NPI or TIN** ____________

Name: ____________________

Address: ____________________

Phone: (______)____________________ Fax: (______)____________________

Check applicable place of service *AND* complete requested information

Place of Service:

❑ Office (11) ❑ Home (12) ❑ Inpatient Hospital (21) ❑ Outpatient Hospital/Observation (22)

❑ Ambulatory Surgery Center (24) ❑ SNF (31) ❑ Other ___________________________________

Requested Dates of Service: From: ______/______/______ To: ______/______/______

Requested CPT/ HCPCS Code(s)	Requested CPT/ HCPCS Code Description(s)	# Visits/ Days/ Units Requested	ICD Code(s)	Diagnosis (ICD Code) Description(s)

DME: ❑ Bilateral ❑ Right ❑ Left / ❑ Purchase ❑ Rental / ❑ Initial ❑ Subsequent

AUTHORIZATION DOES NOT GUARANTEE COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT LIMITS OR PROVIDER CONTRACTUAL LIMITS.

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