Request Form

# Service Event Authorization

Patient's Name: ______________________ DOB: __________ ID# ______________

Referring Provider: ______________________ Tax ID: __________ Fax#: ______________
Name/Clinic

Refer to Provider: ______________________ Tax ID: __________ NPI: ______________
Name/Specialty/Clinic

Phone: ______________________ Fax: ______________________

Diagnosis: ______________________ ICD-10: ______________

ICD-10 Procedure Code requesting: ______________ Description: ______________

CPT Procedure Code requesting: ______________ Description: ______________

Please provide clinical information for justification of need for service.

Place of Service: ______________________

Projected Date of Service: ______________________

Projected End Date of Service: ______________________

Please select one:

☐ Anticipate Outpatient service only.

☐ Anticipate Observations stay for ______ hours.

☐ Anticipate Inpatient Admission for ______ days.

Please indicate if any of the following is suspected to be a cause of the indicated need for the medication:

☐ MVA ☐ Liability ☐ Workers' Compensation ☐ Indicate if this is an emergent request

**Please note:** In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

______________________ ______________ ______________ __________
Provider Contact Name Phone # Fax # Date

Please refer to the Provider Manual for specific information regarding the need for service event authorization.

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