

Authorization Request Form

☐ ROUTINE

DATE: _____

☐ EXPEDITED* - based on the urgency of the **member's health condition**

*The referring provider or member believes that an expedited determination is warranted when the standard decision time frame may jeopardize the member's health or ability to regain maximum functioning.

IPA/LPO _____

Patient Name:	DOB:	PCP:
Member ID#:	Member Phone #:	
Member Address:	City, State:	Zip:

Referral Type:

☐ Inpatient Admit
 ☐ Outpatient Surgery
 ☐ Home Health (SN/ST/PT/OT)
 ☐ DME
 ☐ OP Therapy (ST/PT/OT)
☐ Consultation
 ☐ Follow-up Visit
 ☐ Consult & 1 Follow-up
 ☐ Other: _____
 Diagnostic Procedure: _____
☐ CT/CTA
☐ MRI/MRA
☐ PET Scan

Referring Physician:	Specialty:	
Address:	City, State:	Zip:
Phone #:	Fax #	
Contact Person:		

Requested Provider/Facility:	Phone #	Fax #
Address:	City, State	Zip

If Referring Out-of-Network/POD Please State Reason: (A Peer to Peer may be necessary)

Requested Procedure Description:	CPT Code:	Requested Procedure Date:
Additional Procedure(s):	CPT Code(s):	
Primary Diagnosis/Rule Out:	ICD-9 Code:	Date of Last Office Visit:
Secondary Diagnosis(es):	ICD-9 Code(s):	
Primary Diagnosis/Rule Out: Only required if DOS is after 9-30-14.	ICD-10 Code:	
Secondary Diagnosis(es): Only required if DOS is after 9-30-14.	ICD-10 Code(s):	

Determination Date:	Expiration Date:
Authorization Number:	Reviewer:

ALL REFERRALS FOR HMO PLAN MEMBERS MUST BE MADE TO CONTRACTED PROVIDERS

ALL LABWORK MUST BE SENT TO: Quest Diagnostics or other in-network lab provider.

Send Claims to: SelectCare of Texas, P.O. Box 741107, Houston, TX 77274

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Y0067_MM_AUTHREQ_1113_IA 12/02/2013 HMO_Beaumont