

Fax Authorization Request Form



Date of request: _____

Member Name: _____
Member ID#: _____
Medicaid# _____ DOB _____

**STOP! CHECK GETNHP.COM TO DETERMINE IF
PRIOR AUTHORIZATION IS REQUIRED**

FAX 800-338-4195

Requesting Provider: _____
Provider ID#: _____
Contact _____
Phone: _____
FAX: _____

Request for Pre-Authorization

Authorization #: _____

For office use only

Please attach clinical information to demonstrate medical necessity for the requested service.

Diagnosis Code: _____	Description: _____
Advanced Imaging	
<i>Please attach: brief summary of history, exam findings, diagnostic imaging results, relevant</i>	

Place of Service	Phone: _____	Fax: _____
Code Code Code	Notes	
<input type="checkbox"/> CT	_____	
<input type="checkbox"/> MRI	_____	
<input type="checkbox"/> PET	_____	
<input type="checkbox"/> Other:	_____	

Outpatient Services

Place of Service	Phone: _____	Fax: _____
<input type="checkbox"/> Orthotics	Notes/Procedure Codes	
<input type="checkbox"/> Prosthesis	_____	
<input type="checkbox"/> Medical Equipment	_____	
<input type="checkbox"/> Home Care	_____	
<input type="checkbox"/> Referral to Non-Par Provider	_____	
<input type="checkbox"/> Formulary Overrides (CHP Only)	_____	
<input type="checkbox"/> Other Services	_____	

Elective Admissions ONLY

Scheduled Date	_____	Facility	_____
			Notes:

Diagnoses:			_____
Diagnoses Codes:			_____
Procedures:			_____
Codes:			_____

For Emergency admissions please fax notification to 800-338-4195

√ **For questions about the pre-authorization process please call Care Coordination at 800-765-3805**
 √ **5 business days Advanced Notice is Required**

Care Coordination will fax an authorization letter to you when your request has been completed. If the service(s) is not approved a Care Coordinator will call you with the determination by telephone and in writing