

Authorization | Organizational Determination Request Form

Please return this completed form and supporting documentation by fax to:

Standard Requests: **501-301-1994** | Urgent Requests: **501-301-1986**

By checking the Urgent Requests box or faxing to this number you certify that waiting could place the members life, health or ability to regain maximum function in jeopardy.

Contact information (for the person with whom we need to communicate about this request)

Contact name		Direct phone & Ext
Email	Preferred fax for determination and correspondence	

Member information

First name	Middle initial	Last name	
Member ID number (including prefix)	Member date of birth (mm/dd/yyyy)	Phone	
Member address	City	State	ZIP

Medical service/Procedure/Course of treatment/Device information

Authorization type (Please Check Only One Box)

If this is related to an existing authorization, please provide the authorization number: _____

Inpatient Outpatient

Drug, Under Medical benefit (any healthcare professional administered injection and/or infusion, CAR-T, or gene therapy billed under the medical benefit by provider, facility or specialty pharmacy)

Treatment type (Please Check Only One Box)

Medical	Home Health/	Hospice	High-Tech Radiology
Surgical	Skilled Nursing	Delivery	Medical Oncology
Behavioral	PT/OT/ST	Swing Bed	
	DME	CT/PET Scans, MRIs	

Request type (Please Check Only One Box)

Initial Retrospective Concurrent Org Determination/Benefit Inquiry Only (for codes not on PA list)

Please note: The turnaround time for most OD/BI request is ten (10) business days.

Place of service (Please Check Only One Box)

School	Emergency Room	Hospice	Outpatient Hospital
Office	Ambulatory Surgery	Observation	Neuro Restorative
Home	Center	Rehabilitation Center	Treatment Facility
Inpatient Facility	Skilled Nursing Facility	LTAC	PT/OT/ST

Requestor & Provider details

Requestor: Member Authorized Representative Provider Facility

Requesting provider

Provider name	Tax ID #	NPI #	Specialty
Group/Facility name	Group/Facility NPI #	Phone	
Group/Facility address	City	State	ZIP



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Servicing provider

Provider name

Tax ID #

NPI #

Specialty

Group/Facility name

Group/Facility NPI #

Phone

Preferred Fax

Group/Facility address

City

State

ZIP

Diagnosis and procedure codes (if you have more than three codes for either section, just type the codes separated by commas)

Diagnosis ICD (list primary first)

ICD Description

HCPCS/CPT/CDT code

Code description

Medical reason

Start date

End date

Dose and frequency requested

Details**For inpatient admissions**

Emergent Elective

Admission date & time

Expected discharge date & time

Days requested

Bed type

ICU Adult ICU Pediatric NICU Med Surg Adult Med Surg Pediatric Labor & Delivery

For procedures

Start date

End date

Unit type

Units Days Hours Visits

Units requested

For medical benefit Rx

Start date

End date

Dose

Frequency

Route

Intramuscular (IM) Intravenous (IV) Subcutaneous (SC) Topical (TOP) Other _____

Other clinical information

Include/attach clinical and office notes, laboratory information, imaging reports, and any other necessary information to support this request. If this is a request for out-of-network services, please provide an explanation.

Instructions: Please fill out all applicable sections on all pages completely and legibly before faxing the form to the number listed. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support this request. Information contained in this form is Protected Health Information under HIPAA. If this request is for a prescription drug on the pharmacy benefit or for a transplant, please fill out the applicable form.



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