

# 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)

<b>Contact name</b>		<b>Direct phone &amp; Ext</b>
<b>Email</b>	<b>Preferred fax for determination and correspondence</b>	

## Member information

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

## 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/ Skilled Nursing	Hospice Delivery	High-Tech Radiology Medical Oncology
Surgical	PT/OT/ST	Swing Bed	
Behavioral	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 Center	Observation	Neuro Restorative Treatment Facility
Home	Skilled Nursing Facility	Rehabilitation Center	PT/OT/ST
Inpatient Facility		LTAC	

## Requestor & Provider details

**Requestor:**    Member      Authorized Representative      Provider      Facility

### Requesting provider

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



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**Servicing provider**

<b>Provider name</b>		<b>Tax ID #</b>	<b>NPI #</b>	<b>Specialty</b>
<b>Group/Facility name</b>		<b>Group/Facility NPI #</b>	<b>Phone</b>	<b>Preferred Fax</b>
<b>Group/Facility address</b>		<b>City</b>	<b>State</b>	<b>ZIP</b>

**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

HCCPS/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 &amp; Delivery

**For procedures**

Start date	End date	Unit type				Units requested
		Units	Days	Hours	Visits	

**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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