### Authorization Request Form

**Provider Information**

- **PCP (If Applicable)**
- **Referring Physician’s Name**
- **Requested Provider’s Name**

**Patient Identification**

- **Last Name**
- **First Name**

- **Address**
- **City**
- **State**

- **Phone Number**
- **Date of Birth**
- **ID Number**

**Requested Service / Procedure / Location**

- **Service Type**
  - [ ] Office
  - [ ] Outpatient
  - [ ] Inpatient (Anticipated LOS ____________)

- **Facility Name (Procedure Location)**
- **In-Network**
- **Out-of-Network**

- **Procedure Date** (Please provide "tentative" date if procedure not yet scheduled)

**Diagnosis Description**

**Diagnosis Codes**

**Service / Procedure Description**

**CPT / HCPCS Codes**

**Occupational, Physical and Speech Therapy Requests Only**

- **Number of Visits Requested**
- **Date of Initial Onset**
- **Date of Initial Visit**

Note: This authorization is exclusive of Out-of-Network and/or Non-Contracted facility or provider, unless specifically so authorized.

In order to process your request as quickly as possible, clinical information (chart notes, diagnostic studies, etc.) must be included with this request. For physical medicine requests, include a copy of the initial evaluation, treatment plan, legible progress notes and documentation of compliance with the prescribed home exercise program.

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