Independent Health Prior Authorization Request Form

IH Medical: Phone: (716) 631-3425 Fax: (716) 635-3910
IH Behavioral Health: Phone:(716) 631-3001 EXT 5380 Fax: (716) 635-3776

NOTE: all fields on this form must be completed. If not, delay of determination may result. Please be advised that Independent Health must have the necessary information to process the request timely.

REQUEST FOR:
c **IH MEDICAL Inpatient**
c **IH MEDICAL Outpatient/ Procedure/ Equipment**
c **IH BEHAVIORAL HEALTH Inpatient**
c **IH BEHAVIORAL HEALTH Outpatient/ Procedure**

MEMBER INFORMATION

MEMBER ID: c c c c c c c c c **SUFFIX:** c c
NAME: _____ DOB:_____
Home/Cell Phone: (____) ____–_____ Address: _____ State: ____ Zip Code: _____

REQUESTING PHYSICIAN/PROVIDER INFORMATION:

NAME: _____ **NPI:** c c c c c c c c c c
Office Contact Name:_____ TAX ID: c c – c c c c c c c
Address: _____ City: _____ State: ____ Zip Code: _____
Phone Number: (____) ____–_____ Ext: _____ Fax: (____) ____–_____

RENDERING PHYSICIAN/PROVIDER/FACILITY INFORMATION:

NAME: _____ **NPI:** c c c c c c c c c c
Office Contact Name:_____ TAX ID: c c – c c c c c c c
Address: _____ City: _____ State: ____ Zip Code: _____
Phone Number: (____) ____–_____ Ext: _____ Fax: (____) ____–_____

DIAGNOSIS CODES (ICD-10): **1** _____ **2** _____ **3** _____

REQUESTED SERVICE(S): (ATTACH: copy of physician's order and/or Certificate of Medical Necessity **as well as all** relevant medical records i.e.; evaluations, imaging studies, labs, etc.)

Units HCPCS/ CPT codes	Item Description	Rental or Purchase

DATE OF SERVICE: _____

Would processing this request after seventy-two (72) hours, place the member's life, health or ability to regain maximum function in serious jeopardy? c NO c YES