



Authorization Request Form

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www.HealthFirstHealthPlans.org

Forms without complete information or attached documentation WILL NOT be processed.

MUST COMPLETE

DATE OF REQUEST, CONTACT Name, MEMBER ID#, REQUESTING PROVIDER, PCP

Check the applicable request types(s) below AND complete the requested information.

COMPLETE APPLICABLE INFORMATION FIELDS

OUT OF NETWORK (OON) SPECIALIST REFERRALS, TYPE OF SERVICE, DME PROVIDER, DIAGNOSIS, PROCEDURE, SERVICE DATE, INPATIENT ADMISSION DATE, HIP OR KNEE ARTHOPLASTY

REQUEST FOR EXPEDITED REVIEW, Criteria for expedited review, Check here if you are requesting an expedited decision as described by the criteria above.

USE OF THIS FORM DOES NOT GUARANTEE ELIGIBILITY OF COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT PLAN LIMITATIONS, DME BENEFIT LIMITATIONS OR THE PROVIDER'S CONTRACTUAL LIMITATIONS.

CONFIDENTIALITY: The information contained in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity named above.

AFFIRMATIVE STATEMENT: UM decision making is based only on appropriateness of care and service and existence of coverage.

REVISED: October 2009