JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Authorization Request Form

Note: Incomplete requests will be returned.

FOR EHP, PRIORITY PARTNERS AND USFHP USE ONLY

All fields are mandatory. Chart notes are required and must be faxed with this request.

Please fax to the applicable area: Inpatient Medical: 410-424-4894 Outpatient Medical: 410-762-5205 DME: 410-762-5250	
Patient and Referring Provider Information	
Requesting Provider:	Primary Care Physician:
Patient Name:	DOB:
Patient Address:	Health Plan: ☐ EHP ☐ Priority Partners ☐ USFHP Member ID#:
Facility and/or Provider Information	
Facility :	Provider referred to:
Facility NP#:	NPI#:
Facility TIN#:	TIN#:
Comments :	Address: Phone #:
Admission OR Procedure Information	
☐ **Inpatient Admission** ☐ **Inpatient Prior Authorization**	☐ **Outpatient**
Date of Admissions/Procedure: ICD-10 code(s): CPT code(s):	Requested Service(s): ☐ Office ☐ ASC ☐ SNF/ACIR ☐ Home ☐ Hospital ☐ Procedure ☐ Outpatient PT/OT/ST** ☐ Diagnostics ☐ Other **Send initial evaluation and most recent re-evaluation or progress note
Comments:	Number of visits requested: Requested date span:
Required Requester Information	
Contact Name Contact Phone: Contact Fax:	Expedited Requests are not to be used for scheduling convenience. The urgency of services is to be determined by the ordering provider based on the medical need of the enrollee. ☐ Please expedite! Please refer to the provider manual for EHP, Priority Partners or USFHP authorization response times.
Total pages, including this cover page:	☐ Please review for in-network benefits.