



# Authorization Request Form

**FOR EHP, PRIORITY PARTNERS AND USFHP USE ONLY**

**Note:** All fields are mandatory. Chart notes are required and must be faxed with this request. Incomplete requests will be returned.

<b>Please fax to the applicable area:</b>	EHP & PP DME: 410-762-5250	Outpatient Urgent: 410-424-2707
Inpatient Medical: 410-424-4894	Outpatient Medical: 410-762-5205	Transplant/Bariatric: 410-424-4046
Initial Inpatient: 410-424-2770	SNF/LTAC/ACIR/AMBO Requests: 410-424-2703	USFHP Inpatient: 410-424-2602
BH EHP: 410-424-4891	BH EHP Secured: 410-424-4765	USFHP Outpatient: 410-424-2603
		BH USFHP: 410-424-4839

Effective 5/1/2022 for EHP & Priority Partners NICU Admission or Prior Pediatric Readmission (w/in 1 year of NICU discharge), fax notification and/or clinical information to ProgenyHealth: 888-400-4636

### Patient and Referred Provider Information

Requesting Provider:	Primary Care Physician:
Patient Name:	DOB:
Patient Address:	Health Plan: <input type="checkbox"/> EHP <input type="checkbox"/> Priority Partners <input type="checkbox"/> USFHP
	Member ID#:

### Serving Facility and Provider Information

Facility:	Provider referred to:
Facility NPI#:	NPI#:
Facility TIN#:	TIN#:
Comments:	Address:
	Phone #:

### Admission OR Procedure Information

<input type="checkbox"/> Inpatient Admission <input type="checkbox"/> Inpatient Prior Authorization <input type="checkbox"/> Post-Acute Facility (SNF/ACIR/LTAC) <input type="checkbox"/> Outpatient	
Date of Admissions/Procedure:	Requested Service(s): <input type="checkbox"/> Office <input type="checkbox"/> ASC <input type="checkbox"/> SNF <input type="checkbox"/> ACIR <input type="checkbox"/> LTAC <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Procedure <input type="checkbox"/> Non-Emergent Ambulance <input type="checkbox"/> Outpatient PT/OT/ST** <input type="checkbox"/> Diagnostics <input type="checkbox"/> Other **Send initial evaluation and most recent re-evaluation or progress note.
ICD-10 code(s):	
CPT code(s):	
Comments:	Number of visits requested:
	Requested date span:

### Required Requester Information

Contact Name:	<b>Expedited Requests</b> 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.  <input type="checkbox"/> <b>Please expedite!</b> This provider believes that waiting for a decision under the standard timeframe could place the enrollee's life, health or ability to regain maximum function in serious jeopardy. (CMS definition)
Contact Phone:	
Contact Fax:	
Total pages, including this cover page:	
	<input type="checkbox"/> Please review for in-network benefits.