



AUTHORIZATION REQUEST

FAX TO
(516) 746-6433
or
(888) 746-6433

501 Franklin Avenue, Suite 300
Garden City, New York 11530
Phone: (516) 746-2200 (888) 746-2200

Date: _____

STANDARD (Routine) Request - PLEASE DO NOT USE ASAP, URGENT, or STAT; these are not recognized by CMS.

EXPEDITED Request - **ALL EXPEDITED Requests MUST meet the CMS definition and be Attested to:**
Provider Attestation Required (*Expedited Requests Only*)

Clinical justification for expedited review: _____

By signing below, I certify that applying the standard review timeframe for this service request may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Physician/clinician name: _____ Signature: _____

Member Information

Name (Last, First MI) _____ DOB _____

Address (Street) _____ City, State ZIP Code _____

Health Plan _____ Member ID# _____ Area Code & Telephone No. _____

Referring Physician (PCP or Specialist) _____ **Referred to (HCP or Health Plan Par-Provider)** _____

Name (Last, First MI) _____ Name (Last, First MI) _____

Address (Street, City, State ZIP Code) _____ Address (Street, City, State ZIP Code) _____

Area Code & Telephone No. _____ Area Code & Fax No. _____ Area Code & Telephone No. _____ Area Code & Fax No. _____

Specialty _____ Are you referring to yourself? _____ Specialty _____ if PSN Provider

Requested Service(s) – ALL FIELDS MUST BE COMPLETED

Diagnosis(es): _____ ICD-10 Code(s): _____

Indicate Medical Necessity: _____

Clinical Notes/Reports Attached: Yes No

Service(s) Requested: _____ CPT Code(s): _____

Place of Service: Office (POS11) Home(POS 12DME/Homecare) Outpatient Hospital ON campus (POS 22)

Outpatient Hospital OFF campus(POS 19) Ambulatory Surgery Center (POS 24) Inpatient Hospital (POS 21)

FACILITY NAME: _____

**HealthCare Partners will notify you of the determination made on your request for service(s)
Services Not Prior Approved By HCP, MSO Are Not Payable***

IMPORTANT NOTE TO HCP CONTRACTED AND NON-CONTRACTED PROVIDERS

The approval of the services indicated above refers only to the medical appropriateness of the requested service(s) and does not represent guarantee of payment. Your acceptance of this referral to provide services to the above-referenced member/patient constitutes your agreement to accept payment in accordance with HealthCare Partners, IPA reimbursement fee schedule (which may change from time to time without notice) as payment in full, and look to the member/patient only for payment of applicable co-payment and/or deductibles. *Payment is limited to those service(s) specifically authorized; any additional services require further authorization from HealthCare Partners, MSO subject to modifications as may be posted on the HCP, IPA Website from time to time. You further agree to abide by HealthCare Partners' Claims, Quality and Utilization Management policies currently in effect. **REIMBURSEMENT IS SUBJECT TO MEMBER'S ELIGIBILITY TO RECEIVE BENEFITS ON THE DATE OF SERVICE. Claims for authorized services must be received within 90 days of the date of service to be considered for payment.**