MEDICAL SERVICES
Medicare D-SNP Pre-Authorization Fax: 713-295-7059
Admissions Notification Fax: 713-295-2284
Complex Care Fax: 713-295-7016

BEHAVIORAL HEALTH SERVICES

Medicare
Pre-Authorization OP Fax: 713-576-0930
Pre-Authorization IP Fax: 713-576-0930

COMMUNITY HEALTH CHOICE

Failure to Complete All Applicable Fields May Delay Processing

AUTHORIZATION REVIEW FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Request Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:
Request Type: ☐ Initial Request ☐ Extension ☐ Amendment	Prev. Auth. #:
☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery Other: _____	

SECTION III - PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Plan Name:	

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility		**Service Provider or Facility**	
Name:	Tax ID:	Name:	Tax ID:
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date:		Phone:	Fax:

SECTION V - SERVICES REQUESTED (WITH CPT, CDT, REV OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No Nursing Assessment Attached? ☐ Yes ☐ No)

☐ DME (MD Signed Order Attached? Yes ☐ No ☐ Title 19 Certification Attached? *(Medicaid Only)* Yes ☐ No ☐
Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

☐ Other Services: _____

Planned Service or Procedure	Code (CPT, HCPCS, Revenue Code)	Units	Start Date	End Date	Diagnosis Description	ICD-10 Code

An issuer needing more information may call the requesting provider directly at: _____

***** Required: Attach clinical documentation to this form upon submission.*****