Authorization Request Form Attn: Intake Processing Unit
Phone: 1-844-857-1601 Fax: 1-800-413-8347
Email: auths@dignityhmo.com

Date Request Submitted: ___________

Authorization Type: (Choose appropriate option)

_______**Standard** For request not requiring prioritization (decision made as soon as possible but no later than 14 days) Check here for RETRO request ________

_______**Urgent/Expedited** Request will be reviewed promptly. Request is medically urgent and delay of more than three days could put the member's life, health or ability to regain maximum function in serious jeopardy, and the MD/NP believes the request should be expedited.

_______***Recertification Request*** *Check here if request is in response to a denied claim* ______

Member Name: ________________________________ Member ID:_______________ Date of Birth:_________

Prescribing provider:________________________ Servicing Provider/Facility: ____________________________

Phone: ______________________Fax: ____________________ Email:______________________________

Request Service: ◯ **Inpatient** ◯ **Outpatient** **Is this a scheduled service?** _________________

Dates of Inpatient Admission: ____________________ **Estimated Length of Stay:**____________________

Scheduled or anticipated date of Outpatient services:____

☐ Acute Inpatient Hospital Admission ☐ Psychiatric Inpatient Admission

☐ Skilled Nursing Admission ☐ Inpatient Rehab Admission

____ **Physical Therapy** ____ **Occupational Therapy** ____ **Speech Therapy**
____ **Home Health** ____ **Durable Medical Equipment** ____ **Diagnostic Services**
____ **Specialty Visit** ____ **Part B Medication Request** ____ **Ambulatory/Outpatient Surgery**
____ **Other** ____

_____**Out of Network Inpatient or Outpatient Services**

Notes:____

____

Diagnosis Descriptions: ____

ICD :____

Service Code (CPT, HCPCS, etc) ____

Service Descriptions: ____

Quantity/Frequency/Duration (as applicable): ____

Recertification Request only*; Previously approved dates of services:*________________________

______**Clinicals are attached to support request (all applicable clinicals should be attached) Signed physician order and clinical notes, including a diagnosis that supports your request, are required for all services.**

For Questions regarding this request, contact:
Name: ____

Phone:_________________________Fax: ___________________ Email: ________________________

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

This facsimile message is privileged and confidential. It is transmitted for the exclusive use of the addressee. This communication may not be copied or disseminated except as directed by the addressee. Contact us immediately if you have received this in error.