Health First Health Plans

Authorization Request Form

6450 US Highway 1, Rockledge, FL 32955

Phone: (321) 434-5665 / Toll Free: (800) 716-7737
TDD Relay (800) 955-8771 / Fax: (321) 434-4271

www.health-first.org

Forms without complete information or attached documentation *WILL NOT* be processed.

MUST COMPLETE

DATE OF REQUEST ____/____/_____

CONTACT Name _____ Phone (____)_____-_____ Ext. _____ Fax (____)_____-_____

MEMBER ID#_____ First/Last_____ DOB____/____/____

REQUESTING PROVIDER First/Last _____

❑ PCP / Phone (____)_____-_____ Fax (____)_____-_____

Check the applicable request types(s) below *AND* complete the requested information.

COMPLETE APPLICABLE INFORMATION FIELDS

OUT OF NETWORK (OON) SPECIALIST REFERRALS NPI #_____ / TAX ID #_____

❑ Consult Only ❑ Consult w Diagnostics ❑ Consult/Diagnostics/Treatment ❑ 2ND OPINION

PERFORMING PROVIDER First/Last _____ Specialty _____

Address _____ Phone (____)_____-_____ Fax (____)_____-_____

❑Initial Request ❑Add Visit(s) / # of Office visit(s) _____ / Service date(s) from ____/____/____ to ____/____/____

TYPE OF SERVICE ❑ Office ❑ Outpatient ❑ Observation ❑ Ambulatory Surgery ❑ Inpatient ❑ SNF ❑ PT/OT/ST*

❑DME ❑PROSTHETICS ❑ Other _____ Comment _____

PERFORMING/ADMITTING PROVIDER First/Last _____ _____Specialty _____

Address (OON only) _____ Phone (___) ____-_____ Fax (___) ____-_____

FACILITY _____

Address (OON only) _____ Phone (___) ____-_____ Fax (___) ____-_____

DME PROVIDER Name_____ Equipment _____

HCPCS Code(s)_____ _____ _____ _____ _____ _____ _____ _____

❑ Bilateral ❑Right ❑Left / ❑ Purchase *OR* ❑ Rental : ❑ 1st Month Rental ❑ 2nd or 3rd Month Rental ❑ 4 -15 Month Rental

**** PT/OT/ST initial evaluation & progress notes must accompany request for additional visits***

DIAGNOSIS Description _____ Code(s) (ICD-CM) _____

PROCEDURE Description _____ CPT/HCPCS Code(s) _____

SERVICE DATE(s) FROM ____/____/_____ **TO** ____/____/_____ **# OF SERVICE(s)/UNIT(s) /VISIT(s)** _____

Auth # _____ Authorization Expiration Date: ____/____/_____ Completed by:_____ Phone:(321)_____-_____

INPATIENT ADMISSION DATE _____/_____/_____ Expected discharge date ____/____/_____

HIP OR KNEE ARTHOPLASTY Has the patient completed a HFHP Joint Class? ❑ Yes ❑ No / ❑ Bilateral ❑ Right ❑ Left

Joint Class completed date ____/____/____ Location of Joint Class

REQUEST FOR EXPEDITED REVIEW

Criteria for expedited review: If waiting for a decision in the standard timeframe could seriously harm the members life, health, or ability to regain maximum function, you can ask for an expedited decision.

❑ Check here if you are requesting an expedited decision as described by the criteria above.

USE OF THIS FORM DOES NOT GUARANTEE ELIGIBILITY OF COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT PLAN LIMITATIONS, DME BENEFIT LIMITATIONS OR THE PROVIDER'S CONTRACTUAL LIMITATIONS.

CONFIDENTIALITY: The information contained in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this telecopy is strictly prohibited. If you have received this telecopy in error, please immediately notify the sender above and return the original message to us at the address above by the United States Postal Service. Thank you for your cooperation.

AFFIRMATIVE STATEMENT: UM decision making is based only on appropriateness of care and service and existence of coverage. HFHP does not reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization

REVISED: October 2009