

## Authorization Request Form

Date: \_\_\_\_\_ IPA/LPO \_\_\_\_\_

This request will be treated as per the standard organization determination timeframes. **If the request needs to be treated as expedited, please provide justification** that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

<b>Patient Name:</b>		DOB:		PCP:	
Member ID#:			Member Phone #:		
Member Address:		City:		State: Zip:	
<b>Referral Type:</b>					
<input type="checkbox"/> Inpatient Admit		<input type="checkbox"/> Outpatient Surgery		<input type="checkbox"/> Home Health (SN/ST/PT/OT)	
<input type="checkbox"/> Office Visit		<input type="checkbox"/> Observation		<input type="checkbox"/> DME <input type="checkbox"/> OP Therapy (ST/PT/OT)	
<input type="checkbox"/> Other:					
Diagnostic Procedure/Testing:					
<b>Referring Physician:</b>			Specialty:		
Address:		City:		State: Zip:	
Phone #:		Fax #:			
Contact Person:					
<b>Requested Provider/Facility:</b>			Phone #:		Fax #:
Address:		City:		State: Zip:	
If Referring Out-of-Network Please State Reason:					
<b>Requested Procedure Description:</b>					
CPT Code:			Requested Procedure Date:		
Additional Procedure(s):			CPT Code(s):		
Primary Diagnosis/Rule Out:			Date of Last Office Visit:		
Secondary Diagnosis(es):					
Primary Diagnosis/Rule Out:			ICD – 10 Code:		
Secondary Diagnosis(es):			ICD – 10 Code(s):		

**\*\*PLEASE INCLUDE CLINICAL DOCUMENTATION WITH REQUEST\*\***

**ALL REFERRALS FOR HMO PLAN MEMBERS MUST BE MADE TO CONTRACTED PROVIDERS**

**ALL LABWORK MUST BE SENT TO:** Quest Diagnostics or other in-network lab provider.

Send Claims to: SelectCare of Texas, P.O. Box 17900, Austin, TX 78760-7900

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