

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:

Patient Name:		DOB:		PCP:	
Member ID#:			Member Phone #:		
Member Address:		City:		State: Zip:	
Referral Type:					
<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:					
Referring Physician:			Specialty:		
Address:		City:		State: Zip:	
Phone #:		Fax #:			
Contact Person:					
Requested Provider/Facility:			Phone #:		Fax #:
Address:		City:		State: Zip:	
If Referring Out-of-Network Please State Reason:					
Requested Procedure Description:					
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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