



Fax back to:

Medicare: 1-800-594-5309

Commercial: 1-800-658-9457

Pre-authorization request form

Patient Information		1. Name:	2. Patient DOB:	
			<input type="text"/> / <input type="text"/> / <input type="text"/> <small>MM / DD / YY</small>	
3. Patient Member ID:		4. Gender:	5. Phone:	
		M F		

Referring / PCP Provider		6. Name:		7. Specialty:	
8. NPI	9. Tax ID:	10. Phone:	11. Fax:	12. Contact Person:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

Treating Provider		13. Name:		14. Specialty:	
15. NPI:	16. Tax ID:	17. Phone:	18. Fax:		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

Facility		19. Name:		20. Specialty:	
21. NPI:	22. Tax ID:	23. Phone:	24. Fax:		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

Service Requested			
25. Authorization Type:	26. Category:	27. Place of Service (POS):	28. Service Type:
Inpatient Outpatient	Standard Expedite* Retrospective	Office Home Inpatient Hospital Outpatient Radiology Facility Other _____	Ambulance Ground HighTechnology Diagnostic Studies DME Prosthesis/ Orthotic/ Surgical Trays Home Health Outpatient Surgery/Procedure Transplant (tissue) Chemoteraphy Discharge Planning Specialty Pharmacy Other _____
29. Diagnosis codes:	30. Procedures codes:		
1 <input type="text"/>	1 <input type="text"/>	5 <input type="text"/>	
2 <input type="text"/>	2 <input type="text"/>	6 <input type="text"/>	
3 <input type="text"/>	3 <input type="text"/>	7 <input type="text"/>	
4 <input type="text"/>	4 <input type="text"/>	8 <input type="text"/>	

Clinical Notes or Description of Services Requested		31. Request Date:
		<input type="text"/> / <input type="text"/> / <input type="text"/> <small>MM / DD / YY</small>

Provider Signature	_____ MD	_____
	Name (printed) / Signature	Date

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Notes:
 Provided all necessary documentation when requesting a pre-authorization. Please refer to Humana Pre-Authorization Guide
 Note that the pre-authorization of any procedure does not guarantee **payment; it is subject to benefits, eligibility and coverage at the moment of offering the service.** Approval is based on medical necessity as defined in the patient's benefit plan or certificate. All benefits are subject to patient eligibility, terms, conditions, and exclusions of the benefit plan certificate.

***Expedite** pre-authorizations will be completed within 72 hours or less, once all necessary information is received. According to ERISA and Medicare, an expedite determination can be requested when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.