Humana®

# Pre-authorization request form

**Fax back to:**
Medicare: 1-800-594-5309
Commercial: 1-800-658-9457

| **Patient Information** | 1. Name: | 2. Patient DOB: MM / DD / YY |
|---|---|---|
| 3. Patient Member ID: | 4. Gender: ☐ M ☐ F | 5. Phone: |

| **Referring / PCP Provider** | 6. Name: | 7. Specialty: |
|---|---|---|

| 8. NPI | 9. Tax ID: | 10. Phone: | 11. Fax: | 12. Contact Person: |
|---|---|---|---|---|
| ☐☐☐☐☐☐☐☐☐☐ | ☐☐☐☐☐☐☐☐☐ | | | |

| **Treating Provider** | 13. Name: | 14. Specialty: |
|---|---|---|

| 15. NPI: | 16. Tax ID: | 17. Phone: | 18. Fax: |
|---|---|---|---|
| ☐☐☐☐☐☐☐☐☐☐ | ☐☐☐☐☐☐☐☐☐ | | |

| **Facility** | 19. Name: | 20. Specialty: |
|---|---|---|

| 21. NPI: | 22. Tax ID: | 23. Phone: | 24. Fax: |
|---|---|---|---|
| ☐☐☐☐☐☐☐☐☐☐ | ☐☐☐☐☐☐☐☐☐ | | |

## Service Requested

| 25. Authorization Type: | 26. Category: | 27. Place of Service (POS): | 28. Service Type: |
|---|---|---|---|
| ☐ Inpatient<br>☐ Outpatient | ☐ Standard<br>☐ Expedite*<br>☐ Retrospective | ☐ Office<br>☐ Home<br>☐ Inpatient Hospital<br>☐ Outpatient<br>☐ Radiology Facility<br>☐ Other _____ | ☐ Ambulance Ground<br>☐ HighTechnology Diagnostic Studies<br>☐ DME<br>☐ Prosthesis/ Orthotic/ Surgical Trays<br>☐ Home Health<br>☐ Outpatient Surgery/Procedure<br>☐ Transplant (tissue)<br>☐ Chemoteraphy<br>☐ Discharge Planning<br>☐ Specialty Pharmacy<br>☐ Other _____ |

| 29. Diagnosis codes: | 30. Procedures codes: | | | |
|---|---|---|---|---|
| 1 | 1 | | 5 | |
| 2 | 2 | | 6 | |
| 3 | 3 | | 7 | |
| 4 | 4 | | 8 | |

## Clinical Notes or Description of Services Requested

**31. Request Date:** MM / DD / YY

## Provider Signature

_____ MD
Name (printed) / Signature

_____
Date



**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.