MedStar Health

Authorization Request Form

Visit the provider portal to submit initial authorization requests online at MedStarProviderNetwork.org

Fax completed form to: 1-855-431-8762

Phone number: 1-855-242-4875

*** = Required Information**

***Requestor's Contact Name:** ***Requestor's Contact Number**:

PATIENT INFORMATION

*Member Name: *Date of Birth:

*Member ID Number: *Member Phone Number:

*Service is:
- ☐ Elective/ Routine
- ☐ Expedited/ Urgent *Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.*
- ☐ Extension to Authorization _____
- ☐ Continuity of Care

SERVICE TYPE

- ☐ Inpatient Surgical Procedure
- ☐ Outpatient Surgical Procedure
- ☐ Observation Stay
- ☐ Observation Changed to Inpatient
- ☐ Acute Inpatient
- ☐ Office Visit
- ☐ DME Rental/DME Purchase: $_____
- ☐ Long Term Acute Care
- ☐ Skilled Nursing Facility
- ☐ Acute Rehabilitation
- ☐ Hospice
- ☐ Genetic Testing
- ☐ Home Health
- ☐ Check all that apply: ☐PT ☐OT ☐ST
- ☐ Maternity
- ☐ NICU Stay
- ☐ Mental Health
- ☐ Transplant
- ☐ Imaging
- ☐ Other: _____

PROCEDURE INFORMATION

***ICD-10** Diagnosis: Diagnosis Description:

*CPT Code:_____ *Units:_____ CPT Code:_____ Units:_____ CPT Code:_____ Units: _____

CPT Code:_____ Units:_____ CPT Code:_____ Units:_____ CPT Code:_____ Units: _____

*** Date(s) of Service:**

PROVIDER INFORMATION

Requesting Provider ☐ *Primary Care Physician*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ Phone _____

*Address:

Facility/Vendor ☐ *Same as Requesting*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ Phone _____

*Address:

Attending/Rendering Provider ☐ *N/A*

*Name: _____ *NPI: _____ *TIN: _____

*UR Fax: _____ *UR Phone: _____

*Address:

ALL REQUIRED FIELDS MUST BE FILLED IN. COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION. Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policies and procedures. Other rules may apply. **Confidentiality Notice:** The information contained in this transmission is private, confidential and intended for the individual or entity to which is addressed. This information is also protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient, any use, distribution or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately at Privacy@EvolentHealth.com and destroy this document.