



# PROVIDER AUTHORIZATION FAX REQUEST FORM

Submit online requests for prior authorization (PA) through the **Alliant Health Plans Provider Portal** **OR** you may fax this completed form to Alliant Health Plans Utilization Management at **FAX 866-370-5667**. If you have an urgent case in need of an urgent response, please **CALL (800) 865-5922**.

All requests with a scheduled date of service greater than 3 days from date requested will be processed within the standard turn-around-time. Any request for service with a past date of service will be treated as a post-service prior authorization request; please submit supporting documentation of reason was not able to submit request prior to date of service.

**TODAY'S DATE:** \_\_\_\_\_ **SCHEDULED DATE OF SERVICE:** \_\_\_\_\_

**CONTACT NAME:** \_\_\_\_\_

**CONTACT PHONE:** \_\_\_\_\_ **CONTACT FAX:** \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Provider TIN: \_\_\_\_\_

Provider Address: \_\_\_\_\_

## FACILITY INFORMATION

Facility Name: \_\_\_\_\_

Facility NPI: \_\_\_\_\_ Facility TIN: \_\_\_\_\_

Facility Address: \_\_\_\_\_

## MEMBER INFORMATION

Member Name: \_\_\_\_\_ Member DOB: \_\_\_\_\_

Member ID: \_\_\_\_\_ Member Phone: \_\_\_\_\_

## SERVICE INFORMATION

Service is:  Initial Request  Updated Request  23-Hour Observation  Inpatient  Outpatient

ICD 10 Codes: \_\_\_\_\_

CPT/HCPCS Codes with description: \_\_\_\_\_

## CLINICAL INFORMATION

Please provide comments/clinical record/supporting information to expedite the authorization:

**AND**, See attached clinical information.