

**Outpatient Authorization Request**

You may request and receive authorizations online via the secure provider portal at  
[www.prominencehealthplan.com](http://www.prominencehealthplan.com)

<b>FAX REQUEST TO: (888) 393-2335</b>		
<b>Phone: (844) 894-8086</b>		
<b>PRIORITY LEVEL:</b>	<input type="checkbox"/> Standard/Routine <input type="checkbox"/> Urgent	<b>REQUEST DATE:</b> _____
<b>CHECK ONE OF THE FOLLOWING:</b>		
<input type="checkbox"/> Ambulatory Surgery <input type="checkbox"/> Home Health Services <input type="checkbox"/> Non-Participating Provider <input type="checkbox"/> Rehabilitation Services <input type="checkbox"/> Office visits/procedures <input type="checkbox"/> Hospital Services <input type="checkbox"/> Durable Medical Equipment <input type="checkbox"/> Other: _____		
<b>Required Information:</b> To ensure our members receive quality and timely care, please complete this form in its entirety and submit with appropriate supporting clinical documentation (e.g. H&P, imaging reports, previous treatments)		
<b>MEMBER INFORMATION</b>		
<b>Member ID:</b>	<b>Last Name:</b>	<b>First Name, MI:</b>
<b>Plan or Group #:</b>	<b>Phone Number:</b>	<b>Date of Birth:</b>
<b>ORDERING/REFERRING PROVIDER INFORMATION</b>		
<b>NPI#:</b>	<b>Provider Type/Specialty:</b>	
<b>Tax ID#:</b>		
<b>Last Name:</b>	<b>First Name:</b>	
<b>Street Address:</b>	<b>City, State:</b>	<b>Zip Code:</b>
<b>Phone Number:</b>	<b>Fax Number:</b>	
<b>TREATING PROVIDER INFORMATION</b>		
<b>NPI#:</b>	<b>Provider Type/Specialty:</b>	
<b>Tax ID#:</b>		
<b>Last Name:</b>	<b>First Name:</b>	
<b>Street Address:</b>	<b>City, State:</b>	<b>Zip Code:</b>
<b>Phone Number:</b>	<b>Fax Number:</b>	
<b>FACILITY INFORMATION</b>		
<b>Facility Type:</b> <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Surgical Center		
<b>NPI#:</b>	<b>Facility Name:</b>	
<b>Tax ID#:</b>	<b>Phone Number:</b>	<b>Fax Number:</b>
<b>Street Address:</b>	<b>City, State:</b>	<b>Zip Code:</b>
<b>SERVICES REQUESTED</b>		
<b>Date of Service:</b> /    /		
<b>Primary ICD-10 Code:</b>	<b>Description:</b>	
<b>Secondary ICD-10 Code:</b>	<b>Description:</b>	
<b>CPT/HCPC Codes</b>	<b># of Visits/Units</b>	<b>Frequency</b>

Request for referral does not guarantee authorization. You will receive written notice of the authorization decision by return FAX. Authorization will be valid for at least 90 days, unless otherwise stated. Authorization is not a guarantee of payment. Non-covered services or services rendered to a patient whose coverage is no longer effective are the patient's responsibility. Prominence Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Prominence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. **Note:** This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution of this information is prohibited and punishable by law.