

Additional Clinical Explanation

*Please attach clinical documentation to faxes such as signs, symptoms, history, diagnostic test results, consultant recommendations (if applicable), and plan of treatment. Requests cannot be processed without this documentation. ** Comments:

Severity Clarification:

** **Emergent:** Direct Admission; the member is currently in the hospital; "head in the bed" at the time of request

Additional information and instructions:

Contact information for the person requesting the authorization. This is the person that will be called with questions. If approved the form will be faxed back to this fax number. If denied, the denial letter will be faxed to this number and mailed to the "requesting physician".

Disclaimer Statement

ApexHealth certification determination does not guarantee payment for services. Eligibility for and payment of services are subject to all terms, conditions and limitations of the Summary Plan Description.

Requesting Provider Attestation Statement

I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

Printed Name: _____ Signature: _____ Date: ____ / ____ / ____

Prior Authorization Contact: 800-707-8593