texicare
A Health Affiliate of Texas Mutual

Medical Helpline

# REQUEST FOR PRIOR AUTHORIZATION

## FAX REQUEST AND CLINICAL DOCUMENTATION TO SECURE FAX - *346-707-0018*

## PROVIDER INFORMATION

* ☐ *I have verified benefits & eligibility and acknowledge that there is no coverage for out-of-network providers.*

**Date:** * _____ **Requested by:** * _____ **Call Back # and Ext.:** * _____

**Practice/Facility Name:** * _____ **Fax Number:** * _____

## PATIENT INFORMATION

**Patient:** * _____ **DOB:** * _____

**Member ID #:** * _____ **Member Phone Number:** * _____

**Other Insurance Coverage (OIC):** ☐ Y ☐ N **OIC Carrier:** _____

**OIC Group #/Name:** _____ **OIC Policy #:** _____ **Is OIC Primary?** ☐ Y ☐ N

## AUTHORIZATION INFORMATION

**Service Type:** ☐ Inpatient ☐ Outpatient † ☐ Provider Administered Medication

**Procedure/Admission Type:** ☐ Emergent ☐ Scheduled

**† Outpatient Authorization is based on the patient's plan and clinical documentation may be required**

**Outpatient Observation greater than 23 hours REQUIRES authorization.**

**ALL IP ADMISSIONS REQUIRE CLINICAL DOCUMENTATION TO SUPPORT MEDICAL NECESSITY & LENGTH OF STAY**

**Diagnosis code(s):** * _____

**Procedure code(s):** * _____

_____

**Dosage, Frequency, Route & Units (cycles if chemo):** * _____

_____

**Initial Treatment?** * ☐ Yes ☐ No **Continued Tx?** * **Last DOS:** _____ **Next DOS:** _____

**DME:** * ☐ Purchase **Cost:** _____ ☐ Rental (Start: _____ End: _____) **Cost:** _____

**Ordering/Admitting MD** * _____ **NPI** * _____

**Phone** * _____ **Fax** * _____ **TIN** * _____

**Address** * _____ **City** * _____ **State** * _____ **Zip** * _____

**FACILITY/Site of Service** * _____ **NPI** * _____

**Phone** * _____ **Fax** * _____ **TIN** * _____

**Address** * _____ **City** * _____ **State** * _____ **Zip** * _____

**IP Only: UR Phone Number:** _____ **UR Fax Number:** _____

**Scheduled/Admission Date:** _____ ☐ TBD **DISCHARGED:** ☐ No ☐ Yes **DATE** _____

**NOTES:** _____

***Disclaimer: Authorizations are confirmation of medical necessity only and not a guarantee of payment. Claims are subject to eligibility, all plan provisions, post-claim evaluation and network participation.***

* Indicates a required field

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