



Today's Date:			
Member Information			
Member Last Name	Member First Name	Member ID	Date of Birth
Provider Information <input type="checkbox"/> In-Network <input type="checkbox"/> Out-of-Network			
Requesting Provider		Provider Tax ID/National Provider ID (NPI)	
Requesting Provider Address		Requesting Provider Telephone/Fax Number	
Contact Name		Contact Telephone /Fax Number	
Servicing Provider/Facility <input type="checkbox"/> In-Network <input type="checkbox"/> Out-of-Network			
Name of Servicing Provider		Servicing Provider Tax ID/NPI	
Servicing Provider Address		Servicing Provider Telephone/Fax Number	
Name of Servicing Facility		Servicing Facility Tax ID/NPI	
Servicing Facility Address		Servicing Facility Telephone/Fax Number	
Service Request			
<input type="checkbox"/> Routine <input type="checkbox"/> Expedited		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	
Anticipated Date of Service:			
Diagnosis Code(s):		CPT/HCPS code(s):	
Description of Service:			
Number of visits/units/days:		Start Date:	End Date: Frequency:

Please fill in all applicable data and submit all relevant clinical information for this request.

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