



Highmark Blue Shield
Clinical Services Utilization Management
Authorization Request Form

Submission Instructions: Only One Patient Per Fax. Please print all information.
IMPORTANT! LIMIT FAXED INFORMATION TO JUST RELEVANT CLINICAL INFORMATION THAT SUPPORTS MEDICAL NECESSITY FOR THE REQUEST. A REVIEW **CANNOT** BE PROCESSED WITHOUT IT- Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.
 Please fax completed form to Clinical Services: **OUTPATIENT: 888.236.6321 or 800.670.4862 (Delaware)**
INPATIENT: 800.416.9195 or 877.650.6069 (Delaware)

Is this a request for an out of network gap exception?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
Patient Name:				
Patient Date of Birth (mm/dd/yyyy):				
Patient ID/UMI Number (with Prefix):				
Name of Requestor/Contact Person:				
Requesting Provider Name:				
Requesting Provider NPI:		Requesting Provider BSID:		
Requesting Provider Address				
Street:				
City:				
State:		Zip Code:		
Requestor's Phone Number:				
Requestor's Fax Back Number:				
Primary Diagnosis Code(s):				
Primary Diagnosis Description(s):				
Procedure/Service CPT Codes(s)				
Type of Service Requested: (Please designate Inpatient Planned or Outpatient Planned for elective surgical procedures)		<input type="checkbox"/> Inpatient Planned (Elective)	<input type="checkbox"/> Inpatient Urgent - Initial	<input type="checkbox"/> Home Health
		<input type="checkbox"/> Inpatient Planned – Continued Stay	<input type="checkbox"/> Inpatient Urgent - Continued Stay	<input type="checkbox"/> Durable Medical Equipment (DME)
		<input type="checkbox"/> Skilled Nursing Facility Transfer	<input type="checkbox"/> Outpatient Planned Surgery	<input type="checkbox"/> Physical Therapy
		<input type="checkbox"/> Inpatient Rehab Facility Transfer	<input type="checkbox"/> Other Ancillary service/procedure	<input type="checkbox"/> Occupational Therapy
		<input type="checkbox"/> LTAC Transfer	<input type="checkbox"/> Hospice	<input type="checkbox"/> Speech Therapy
		Type of Admission/Request:		<input type="checkbox"/> Elective
Inpatient Admission Date or Start of Care Date (mm/dd/yyyy):				
Number of requested visits / units (If applicable):				
Facility Name:				
Facility NPI:		Facility BSID:		
Facility Address				
Street:				
City:				
State:		Zip Code:		
Admitting/Service Provider's Name:				
Admitting/Service Provider's NPI:		Admitting / Service Provider BSID:		
Admitting/Service Provider's Address				
Street:				
City:				
State:		Zip Code:		

This information is issued by Highmark Blue Shield on behalf of its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania and 13 counties in northeastern New York. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware and 8 counties in western New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.