HIGHMARK

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 INFORMATIOM 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** ☐ **No** ☐		
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)**	☐ **Inpatient Planned (Elective)**	☐ **Inpatient Urgent - Initial**	☐ **Home Health**
	☐ **Inpatient Planned – Continued Stay**	☐ **Inpatient Urgent - Continued Stay**	☐ **Durable Medical Equipment (DME)**
	☐ **Skilled Nursing Facility Transfer**	☐ **Outpatient Planned Surgery**	☐ **Physical Therapy**
	☐ **Inpatient Rehab Facility Transfer**	☐ **Other Ancillary service/procedure**	☐ **Occupational Therapy**
	☐ **LTAC Transfer**	☐ **Hospice**	☐ **Speech Therapy**
Type of Admission/Request:	☐ **Elective**	☐ **Urgent / Emergent**	☐ **Non-Urgent**
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/Servicing Provider's Name:			
Admitting/Servicing Provider's NPI:		**Admitting / Servicing Provider BSID:**	
Admitting/Servicing Provider's Address:	**Street:**		
	City:		
	State:		**Zip Code:**