Organizational Determination Request | Benefit Inquiry

Please return this completed form and supporting documentation by fax to:
Standard Requests: **501-301-1994** | Urgent Requests: **501-301-1986**

Contact information (for the person with whom we need to communicate about this request)

Contact name	Direct phone & Ext

Email	Preferred fax for determination and correspondence

Member information

First name	Middle initial	Last name

Member ID number (including prefix)	Member date of birth (mm/dd/yyyy)	Phone

Member address	City	State	ZIP

Medical service/Procedure/Course of treatment/Device information

Authorization type

If this is related to an existing authorization, please provide the authorization number: _____

☐ Inpatient ☐ Outpatient

☐ Medical Benefit Drug (any healthcare professional administered injection and/or infusion, CAR-T, or gene therapy billed under the medical benefit by provider, facility or specialty pharmacy)

Treatment type (check applicable boxes)

☐ Medical
☐ Surgical
☐ Behavioral
☐ Home Health/Skilled Nursing
☐ PT/OT/ST
☐ DME
☐ Hospice
☐ Delivery
☐ Swing Bed
☐ CT/PET Scans, MRIs
☐ High-Tech Radiology
☐ Medical Oncology

Request type (check applicable boxes)

☐ Out of Network ☐ Pre-Notification ☐ Benefit Inquiry / Review ☐ Out of Network Exception

Place of service

☐ School
☐ Office
☐ Home
☐ Inpatient Facility
☐ Emergency Room
☐ Ambulatory Surgery
☐ Center Skilled Nursing
☐ Facility Hospice
☐ Observation
☐ Rehabilitation Center
☐ LTAC
☐ Outpatient Hospital
☐ Neuro Restorative Treatment Facility
☐ PT/OT/ST

Provider details

Requestor: ☐ Member ☐ Authorized Representative ☐ Provider ☐ Facility

Requesting provider

Provider name	Tax ID #	NPI #	Specialty

Group/Facility name	Group/Facility NPI #	Phone

Group/Facility address	City	State	ZIP

Servicing provider

Provider name	Tax ID #	NPI #	Specialty

Group/Facility name	Group/Facility NPI #	Phone	Preferred Fax

Group/Facility address	City	State	ZIP

Diagnosis and procedure codes

Diagnosis ICD (list primary first)	ICD Description

HCPCS/CPT/CDT code	Code description	Medical reason	Start date	End date	Dose and frequency requested

Details

For inpatient admissions & transplants

☐ Emergent ☐ Elective

Admission date & time	Expected discharge date & time	Days requested

Bed type

☐ ICU Adult ☐ ICU Pediatric ☐ NICU ☐ Med Surg Adult ☐ Med Surg Pediatric ☐ Labor & Delivery

For procedures

Start date	End date	Unit type ☐ Units ☐ Days ☐ Hours ☐ Visits	Units requested

For medical benefit Rx

Start date	End date	Dose	Units requested

Route

☐ Intramuscular (IM) ☐ Intravenous (IV) ☐ Subcutaneous (SC) ☐ Topical (TOP) ☐ Other _____

Other clinical information

Include/attach clinical and office notes, laboratory information, imaging reports, and any other necessary information to support medical necessity. If this is a request for out-of-network services, please provide an explanation.

Instructions: Please fill out all applicable sections on all pages completely and legibly before faxing the form to the number listed. Attach any additional documentation that is important for the review (e.g. chart notes, lab data) to support this request. Information contained in this form is Protected Health Information under HIPAA.