



**\*\*PLEASE PRINT\*\***

**Request Date:** \_\_\_\_\_ **Requestor's**  
**Name:** \_\_\_\_\_  
 Phone #: (□□□)□□□-□□□□  
 Fax #: (□□□)□□□-□□□□  
**Requesting Provider:** \_\_\_\_\_  
**Requesting Provider NPI:** \_\_\_\_\_

**Review Type:**  Admission/Initial  Inpatient  
 Retrospective  Outpatient  
 Pre-determination completed  Yes  No  
 If yes:  Approved  Denied Date: \_\_\_\_\_  
**Out of Network request:**  Yes  No

**REQUEST DETAILS**

**Place of Service:**  
 Home  Inpatient  Outpatient  
 Physician Office

**Type of Service:**  
 Physical Health  Behavioral Health

**Severity:**  
 Standard (non-urgent)  Expedited/Urgent

By checking the urgent box, you attest that applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function or subject the member to severe pain that cannot be adequately managed.

Other \_\_\_\_\_

**MEMBER INFORMATION**

Member Name: \_\_\_\_\_  
 (Last, First, Middle)  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Date of Birth: □□ / □□ / □□  
 Member ID #: □□□□□□□□□□□□-□□  
 Phone #: (□□□)□□□-□□□□  
 Sex:  Male  Female  Unknown  
 Age: □□□

**FACILITY INFORMATION**

Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: (□□□)□□□-□□□□  
 Fax #: (□□□)□□□-□□□□  
 TIN #: □□□□□□□□□□  
 NPI #: □□□□□□□□□□  
 (Required)  
**Out of Network:**  Yes  No

**PROCEDURE/SERVICE**

Primary Diagnosis: \_\_\_\_\_  
 Primary Diagnosis Code: \_\_\_\_\_  
 Secondary Diagnosis: \_\_\_\_\_  
 Secondary Diagnosis Code: \_\_\_\_\_  
 Service/Procedure Code: \_\_\_\_\_  
 Description: \_\_\_\_\_  
 Start Date: □□ / □□ / □□  
 End Date: □□ / □□ / □□  
 Units: \_\_\_\_\_  
 Days  Units  Visits (check one)

**\*\*PLEASE PRINT\*\***



SERVICING PROVIDER (e.g. DME or Home Health)	ADMITTING/SERVICING PHYSICIAN
Name: _____	Name: Last, First, Middle _____
Address: _____	Specialty: _____
Phone #: (□□□)□□□-□□□□	Address: _____
Fax #: (□□□)□□□-□□□□	Phone #: (□□□)□□□-□□□□
TIN #: □□□□□□□□□□	Fax #: (□□□)□□□-□□□□
NPI #: □□□□□□□□□□	TIN #: □□□□□□□□□□
<b>(Required)</b>	NPI #: □□□□□□□□□□
Out of Network: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>(Required)</b>
	Out of Network: <input type="checkbox"/> Yes <input type="checkbox"/> No

**Notes: Please list additional CPT codes, prior treatment history, current treatment plan and other pertinent information in this area.**

**SUPPORTING DOCUMENTATION**

Only submit clinical information that supports the request for service(s) to determine medical and/or psychological necessity or specifically requested.

Type of Review Request	Documentation
All Types of Review Requests	Documentation not included in the review request form that supports the medical or psychological necessity of the requested services.
<b>Urgent Review Requests</b>	Requests can only be submitted as urgent <b><i>if applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function or subject the member to severe pain that cannot be adequately managed.</i></b>

**Disclaimer Statement**

*Toney Healthcare Consulting certification determination is based on the information provided herein and is not a guarantee of payment or coverage. Benefits are subject to eligibility and limitations at the time of service. Final payment and coverage determinations shall be made in accordance with the terms, conditions, limitations and exclusions as set forth under the US Family Health Plan policy.*

**Requesting Provider Attestation Statement**

*I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical and/or behavioral health services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician or behavioral health provider.*

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**UR/Pre-Authorization Contact: 866-560-9069**

CONFIDENTIALITY NOTICE: This fax / electronic transmission and its attachments may contain PRIVILEGED and CONFIDENTIAL INFORMATION and / or PROTECTED PATIENT HEALTH INFORMATION (PHI) intended solely for the use of US Family Health Plan and the recipient(s) named above. If you are not the intended recipient, employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any review, disclosure, distribution, dissemination, printing or copying of this fax transmission and /or any attachments is strictly prohibited. If you have received this transmission in error, please notify the sender immediately and permanently delete and destroy this document and any attachments.