



**METCARE 2010
IN-NETWORK
PRIOR AUTHORIZATION FORM**

Please check insurance type:

CarePlus CareOne Plan

Humana Gold Plus (Plan number can be found on member ID card) H5426-001 H5426-002
H5426-008 H5426-019 H5426-013 SNP (Formerly AdvantageCare Plan) H1036-047

MUST check request status: () ROUTINE () STAT/URGENT (Meets the following definition: any condition where failure to provide immediate response may result in an IRREVERSIBLE SIGNIFICANT, ADVERSE outcome of health and/or function)

REQUEST DATE: _____ APPOINTMENT DATE: _____

MEMBER'S PRIMARY CARE PHYSICIAN: _____

NAME OF REQUESTING PHYSICIAN: _____ Specialty: _____

PHONE WITH AREA CODE: _____ FAX WITH AREA CODE: _____

MEMBER LAST NAME: _____ MEMBER FIRST NAME: _____

MEMBER ID NUMBER: _____ DATE OF BIRTH: _____

REFERRED TO PARTICIPATING SPECIALIST:	REFERRED TO PARTICIPATING FACILITY:
TAX ID #	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient TAX ID #
PROVIDER ADDRESS:	FACILITY ADDRESS
PROVIDER PHONE: ()	FACILITY PHONE: ()
PROVIDER FAX ()	FACILITY FAX ()

***Please send clinical notes with request that show Medicare criteria for medical necessity are met.**

ICD9 DIAGNOSIS CODE(S)/DESCRIPTION	CPT PROCEDURE CODE(S)/DESCRIPTION
/	/
/	/
/	/
/	/

Payment for services is subject to member benefit limitations and contract exclusions, and is further limited by the member's eligibility at the time service is rendered. This authorization is not, and shall not be relied upon as, a guarantee of payment.

**FAX COMPLETED FORM ALONG WITH ALL SUPPORTING DOCUMENTATION TO:
Prior Authorization Fax # 888-805-0177 STAT Request Fax # 888-805-0199**