

# Authorization Request Form



Please complete this form, attach relevant clinical information, and fax to (844) 965-9053.  
For faster submission, and to check status, complete this form on [provider.hioscar.com](http://provider.hioscar.com)

## Member information

First name	Last name
Date of birth	Member osc#

## Requestor information

First name	Last name
Affiliation: <input type="checkbox"/> Attending/billing provider <input type="checkbox"/> Ordering/referring provider <input type="checkbox"/> Facility	

## Provider information

Select one: <input type="checkbox"/> Attending/billing provider <input type="checkbox"/> Ordering/referring provider	
Specialty:	
Provider NPI	Provider TIN
Provider full name	
Phone number (+ ext.)	Fax number

## Facility/Vendor information (if applicable)

Facility NPI	Facility TIN
Facility name	
Facility address	
Phone number (+ ext.)	Fax number

## Diagnosis codes (list primary first)

ICD 10
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## Dates of service

Requested start date (MM/DD/YY)	Select one <input type="radio"/> <b>Pre-Service:</b> prior to the start of care or admission <input type="radio"/> <b>Concurrent:</b> during ongoing course of treatment or admission <input type="radio"/> <b>Post-Service:</b> after treatment provided or discharge
Requested end date (MM/DD/YY)	
Number of requested days (inpatient only)	

## Service information

*Instructions: Select either inpatient or outpatient, then one service type and one place of service from the corresponding sections.*

### Inpatient

#### Service type

- Emergency Admission
- Direct Hospital Admission
- Post-Acute Inpatient Admission
- Elective Surgical or Non-Surgical Service

#### Place of service

- Inpatient Hospital
- Hospital - Neonatal ICU
- Skilled Nursing Facility (SAR)
- Comprehensive Rehab Facility
- Long Term Acute Care Hospital (LTACH)
- Inpatient Hospice

### Outpatient

#### Service type

- Imaging Services
- Home Health Care
- Durable Medical Equipment
- Non-Emergent Transportation
- Physician-Administered Specialty Drugs
- Laboratory Services
- Elective Surgical or Non-Surgical Service

#### Place of service

- Outpatient Hospital
- Office
- Home
- Ground Ambulance
- Air/Water Ambulance
- Independent Laboratory
- Comprehensive Rehab Facility
- Ambulatory Surgical Center

## Procedures

Select a unit of measurement: <input type="checkbox"/> Unit <i>or</i> <input type="checkbox"/> Visit	
Procedure code	Quantity
Procedure code	Quantity
Procedure code	Quantity
Procedure code	Quantity

## Existing Case (if extension/renewal)

Case number (e.g. AECISTB8)
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This form is for authorization requests covered under the member's medical benefit that are reviewed by Oscar (not one of our partners/UM delegates).

- To confirm auth requirements, please navigate to <https://www.hioscar.com/prior-authorization> or call us at 855-OSCAR-55.
- To confirm authorization procedures and/or delegated services please refer to our Provider Manual accessible on <https://www.hioscar.com/providers>.

Expedite this request: appropriate if member is suffering from a condition that may seriously jeopardize their health, life, or ability to regain maximum function, or if they are undergoing a concurrent course of treatment.