Authorization Request Form

Please complete this form, attach relevant clinical information, and fax to (844).965.9053 for Individual Family Plans and (833).554.9046 for Medicare Advantage. For faster submission, and to check status, complete this form on provider.hioscar.com

AdventHealth Advantage Plans

Urgency

☐ Standard Request

☐ Urgent Request: Provider certifies that the standard review time frame would seriously jeopardize the member's life or health or ability to regain maximum function

Clinical reason for urgency:

_____

Provider Signature:

_____

Member information

First name	Last name
Date of birth	Member osc#

Requestor information

First name	Last name
Affiliation: ☐ Attending/billing provider ☐ Ordering/referring provider ☐ Facility	

Provider information

Select one: ☐ Attending/billing provider ☐ 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

Dates of service

Requested start date (MM/DD/YY)
Requested end date (MM/DD/YY)
Number of requested days (inpatient only)

Select one

- ○ **Pre-Service**: prior to the start of care or admission
- ○ **Concurrent**: during ongoing course of treatment or admission
- ○ **Post-Service**: after treatment provided or discharge

Service information

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

☐ Inpatient service information

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 information

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 Imaging Center
- ◦ Hospital
- ◦ Physician's Office
- ◦ Home
- ◦ Ground Ambulance
- ◦ Air Ambulance
- ◦ Ambulatory Surgical Center
- ◦ Ambulatory Surgical Center Lab

Procedures

Procedure code	Type (unit or visit)	Quantity
Procedure code	Type (unit or visit)	Quantity
Procedure code	Type (unit or visit)	Quantity
Procedure code	Type (unit or visit)	Quantity

Existing Case (if extension/renewal)

Case number (e.g. AECISTB8)

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 and delegated service procedures please refer to our Provider Manual accessible at https://www.hioscar.com/providers/resources/health_first or access our provider portal at provider.hioscar.com.