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

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 name		
Facility address		
Fax number		

Diagnosis codes (list primary first)

ICD 10

Dates of service

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
 - 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

Place of service

Inpatient Hospital

Hospital - Neonatal ICU

 Long Term Acute Care Hospital (LTACH)

Skilled Nursing Facility (SAR)

Comprehensive Rehab Facility

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

Procedure code	Type (unit or visit)	Quantity
Procedure code	Type (unit or visit)	Quantity
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Existing Case (if extension/renewal)

Case number (e.g. AECISTB8)

Procedures

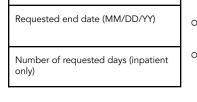
This form is for authorization requests covered under the member's medical benefit that are reviewed by Oscar, not one of our partners/UM delegates. To confirm auth requirements and delegated service procedures please refer to our Provider Manual accessible at

https://www.hioscar.com/providers/resources/health_first or access our provider portal at provider.hioscar.com.

Requested start date (MM/DD/YY) O Pre-Service: prior to the start of care O Concurrent: during ongoing course

Select one

O Post-Service: after treatment provided or discharge





or admission

of treatment or admission