

Authorization Request Form - Part 1

Complete and fax this authorization request form, including supporting clinical documentation to **857-557-6787**.

i Still faxing? If so, you may be missing out on timesaving benefits, including automatic approvals and guided submissions only available when using the Cohere portal to manage authorizations. Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit www.coherehealth.com/register to begin.

Patient information	First name <i>*required</i>		Last name <i>*required</i>			
	Member ID <i>*required</i>			Date of birth (MM/DD/YYYY) <i>*required</i>		
Submitter Contact Information	Submitter first name <i>*required</i>		Submitter last name <i>*required</i>			
	Submitter email <i>*required if phone number not supplied</i>					
	Submitter fax number			Submitter phone number <i>*required if email not supplied</i>		
Diagnosis	Primary diagnosis code <i>*required</i>		Secondary diagnosis code		Secondary diagnosis code	
Service(s) requested	Site of service (please completely fill in one option <input type="radio"/>) <i>*required</i> <input type="radio"/> Inpatient <input type="radio"/> Outpatient					
	Place of service (please completely fill in one option <input type="radio"/>)		CPT/HCPCS code <i>*required</i>		Number of service dates <i>*reqd.</i>	
	<input type="radio"/> 24 Ambulatory Surgical Center					
	<input type="radio"/> 62 Comprehensive Outpatient Rehabilitation Facility		CPT/HCPCS code		Number of service dates	
	<input type="radio"/> 11 Office		CPT/HCPCS code		Number of service dates	
	<input type="radio"/> 21 Inpatient Hospital		CPT/HCPCS code		Number of service dates	
	<input type="radio"/> 19 Off Campus-Outpatient Hospital		CPT/HCPCS code		Number of service dates	
<input type="radio"/> 22 On Campus-Outpatient Hospital		CPT/HCPCS code		Number of service dates		
<input type="radio"/> Other _____		CPT/HCPCS code		Number of service dates		
Expected Start Date (MM/DD/YYYY) <i>*required</i>			Expected End Date (MM/DD/YYYY) <i>*required when applicable</i>			
Requesting Provider	Name <i>*required</i>					
	Street address					
	City		State		Zip code	
	National Provider Identifier (NPI) <i>*required</i>			Provider Tax ID number <i>*required</i>		
	Fax number			Phone number		

Continued on following page

The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information

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Performing physician (or other clinician)	<input type="checkbox"/> Fill this checkbox to indicate that the performing provider is the same as the requesting provider		
	Name		
	Street address		
	City	State	Zip code
	National Provider Identifier (NPI)		Provider Tax ID number
	Fax number		Phone number
Facility	Facility Name <i>*required</i>		
	National Provider Identifier (NPI) <i>*required</i>		Facility Tax ID number <i>*required</i>
Expedite request	<input type="radio"/> Expedite this request In order for a case to be expedited the physician (or other clinician) must indicate that applying the standard timeframe could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. If the date of service is greater than 3 days in the future, please DO NOT submit this request as expedited.		
	Please provide physician (or other clinician) justification		
	Physician (or other clinician) signature		

Please attached relevant clinical documentation after form