Request for Authorization

Phone: 888-339-7982 (Option 3) **Fax: 207-253-6228**

Today's Date	Requesting Provider	Fax
Phone	Submitted By	

Patient's Name	Certificate Number	Date of Birth
Primary Care Provider	**Please Indicate Insurance Type:** ☐ **US Family Health Plan** (Tricare) ☐ **Generations Advantage** (Medicare Advantage)	

Refer To	Address	Referral Provider Specialty
Diagnosis (code preferred)	Anticipated Date of Service	
Medical Information, including out of network statement of medical necessity		

Home, Office, Outpatient Services

- ☐ Out of Network Office Visits: _____
- ☐ Speech Therapy
- ☐ Other
- ☐ Surgery (complete section below)
- ☐ Medication
- ☐ Home Health
- ☐ DME/Medical Supplies (HCPCS Code)
- ☐ Oncology

Facility Services

Procedure	CPT Code
Diagnosis	ICD Code
Hospital of Facility Name	Attending Physician
Please Select One ☐ Inpatient ☐ Outpatient ☐ Observation Stay	
Anticipated Date of Admission	Expected Length of Stay
Inpatient Pre-op Day Requested ☐ Yes ☐ No	

Martin's Point will return incomplete Request for Authorization forms to ensure complete information for processing. **Notice to Members and Providers:** A physician referral for services or Request for Authorization is not a guarantee of payment for those services.

Revised 08/09