EHP MEDICAL MANAGEMENT

PHONE: 216-986-1050 Toll Free 888-246-6648 | FAX: 216-442-5791

Please attach this form to the medical records that support the request. Completion of this form does not guarantee approval. Requests are reviewed based on provided information. Decisions will be faxed to the requesting provider*.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **PATIENT INFORMATION**   |  |  |  | | --- | --- | --- | | **PATIENT NAME (LAST,FIRST)** | **DOB** | **INSURANCE ID#** |   **PROVIDER INFORMATION**   |  |  |  | | --- | --- | --- | | **DATE** |  |  | | **CONTACT NAME & TITLE** | **PHONE NUMBER** | **FAX NUMBER** | | **REFERRING PROVIDER/FACILITY** | **ADDRESS** | **NPI #** | | **SERVICING PROVIDER/FACILITY** | **ADDRESS** | **NPI #** |   **PROCEDURE/SERVICE(S) REQUESTED**   |  |  |  |  | | --- | --- | --- | --- | | **INPATIENT**  ACUTE \_\_\_\_\_\_\_\_  SNF \_\_\_\_\_\_\_\_  REHAB \_\_\_\_\_\_\_\_  LTAC \_\_\_\_\_\_\_\_ | **OUTPATIENT**  LAB(S) \_\_\_\_\_\_\_\_\_  IMAGING \_\_\_\_\_\_\_\_\_  DME \_\_\_\_\_\_\_\_\_ | | HOME  HEALTHCARE \_\_\_\_\_\_\_\_\_\_\_  OTHER \_\_\_\_\_\_\_\_\_\_\_\_ | | **SERVICE DESCRIPTION**: | | **CPT/PROCEDURE(PX)/HCPCS CODE(S):** | | | **DATE OF SERVICE:** | | **DIAGNOSIS(DX)CODE(S):** | |   **EXTENSION OR CHANGE REQUEST**   |  |  | | --- | --- | | **REFERRAL/AUTH #** | **DESCRIPTION OF CHANGE REQUESTED** | |

**CONFIDENTIAL PHI-INCLUDE A COVERSHEET**