IHP

Integrated Health Partners

Outpatient Authorization Form

Phone #: (269) 425-7110
Fax #: (269) 425-7162

Date _____/_____/_____

PATIENT INFORMATION

BCN_____ Group #_____ ☐ N/A

BCN Group # ☐ **00609868** ☐ **00291654** ☐ **00609563**

Patient Name:_____ Phone: _____

Patient Contract #:_____ DOB: _____/_____/_____

PROVIDER/SPECIALTY

Referred BY Provider: _____ Provider NPI #:_____

Referred TO Provider: _____ Provider NPI #:_____

Facility/Hospital: _____ Facility NPI #:_____

REQUESTED SERVICES

Services Start Date ____/____/_____ Services End Date: ____/____/_____ # of Visits:_____

TYPE OF SERVICE (Circle One): OV OP OPS DME MH ER PT/OT/SPEECH OB IP

Level of Care (Check One): [ ] Consult Only [ ] Consult w/Diagnostics [ ] Global

ICD-10 Code 1):_____2):_____3):_____4):_____

Diagnosis _____

CPT Code 1):_____2): _____3):_____4):_____

Procedure _____

Office Contact:_____ Phone #:_____ Fax #:_____

IHP Office Use Only

#	No Authorization Required	Approved	Denied	Redirected to In-Network Provider	Disagree with Redirection
	☐	☐	☐	☐	☐

This referral authorization is valid only for the provider and services listed. An additional referral authorization is required if further services other than those indicated above are necessary. Only those health services covered by the policy/plan of the member/covered person/eligible person at the time of services are eligible for reimbursement, even if ordered by a physician.

Referral Type: ☐ Clinical Review ☐ Routine Referral

Classification: ☐ Info Not Received ☐ Contract Termed ☐ Benefit Limitation ☐ Medical Policy ☐ No PCP Referral ☐ Benefit Exclusion ☐ Medical Necessity

☐ Preservice Urgent (72 hours) ☐ Preservice Nonurgent (7 days) ☐ Post service (30 days)

Met decision time frame: ☐ Yes ☐ No

Received Date and Time: _____ Completed: _____ Decision Made: _____

Clinical Documentation Requested Date: _____ Clinical Documentation Received Date: _____ Date Provider Notified: _____

IHP Medical Director Review Date: _____ Plan Medical Director Review Date: _____ Date Patient Notified: _____