# Request for Authorization

## General Information

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|---|---|
| Date: # Pages Sent : | Review Type: Non-Urgent Urgent |
| Contact Name: | Request Type: Initial Request Extension/Renewal/Amendment |
| Contact Phone: Fax: | Previous Auth # (if applicable): |

## Provider Information

| Requesting Provider or Facility | | Servicing Facility | |
|---|---|---|---|
| Name: | | Facility Name: | |
| Address: | | Address: | |
| NPI#: | TaxID: | NPI#: | TaxID: |
| Phone: | Fax: | Facility Phone: | Fax: |
| Requesting Provider's Specialty: | | | |

**Servicing Provider** (if different than Requesting Provider)

| | | |
|---|---|---|
| Provider Name: | Phone: | Fax: |
| Address: | | |
| NPI#: | TaxID: | Servicing Provider's Specialty: |

## Patient Information

| | | |
|---|---|---|
| Name (Last, First): | DOB: | Phone: |
| Subscriber Name (If Different): | Patient's Member ID#: | |

## Services Requested and Supporting Diagnoses

| Service Code (CPT, HCPCS etc) | Service Description | Start Date | End Date | Diagnosis Code(s) | Diagnosis Description |
|---|---|---|---|---|---|
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Inpatient Outpatient Observation Office Home Other:

Physical Therapy Occupational Therapy Speech Therapy Home Health Mental Health/ Substance Use Other:

Number of Visits/Sessions: Duration: Frequency:

DME Equipment/Supplies Description (include any HCPCS Codes): Duration:

## Additional Information

Additional Clinical Information or Comments As-Needed:

**Submit Request to Vxtra Health-Fax to: 404-835-7893** **For Clinical or Prior Authorization Questions call 877-202-0990**

**www.vxtrahealth.com**