Horizon

Horizon Blue Cross Blue Shield of New Jersey

Fax Authorization Request Cover Sheet

Please attach all relevant medical records that support this request.

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

RETURN FAX NO.:

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FAX NUMBER DIRECTORY			
	Fax No.		**Fax No.**
Requests for Prior Authorization	1-877-798-5903	Requests for IV Infusion Services	1-800-492-2580
Requests for Unite Here Health (Local 54) Members	1-888-891-8913	Requests for Home Care Services	1-800-492-2580
Requests for Horizon BCBSNJ Employees	1-877-798-5903	Requests for Infertility Services	1-973-274-4410

Patient/Subscriber Information:

Patient Name: _____ (Last) _____ (First) _____ (MI) ID#: _____

DOB: _____ (MM) / _____ (DD) / _____ (YYYY) Gender: ☐ M ☐ F

Subscriber Name: _____ (Last) _____ (First) _____ (MI)

Relationship to patient: ☐ Self ☐ Spouse ☐ Child Is there any other Insurance? ☐ Yes ☐ No If so, name of other insurance carrier: _____

Physician Information:

Ordering Physician: _____ ☐ PCP or ☐ Specialist NPI/TIN#: _____

Contact Person: _____ Phone #: _____ – _____ – _____ Ext: _____ Fax #: _____ – _____ – _____

Office Location: _____ Was patient referred by PCP? ☐ Yes ☐ No If the physician in non par, is the member aware? ☐ Yes ☐ No

Service That Authorization Is Being Requested:

☐ Elective In-Patient Admission	☐ Referral to Non-Par Specialist	☐ Pain Management	☐ Bariatric Procedures	☐ DME Rentals
☐ Out-patient Hospital	☐ Excision of Lesion(s) - In Office	☐ Lab	☐ Speech Eval/Therapy	☐ DME Purchase over $500

STAT requests can only be made by the ordering physician, where the physician indicates (and supplies supporting documentation) that applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
Any request for retrospective authorization will not be considered on a STAT basis.

These services do NOT reflect ALL services requiring authorization. Provider Services 1-800-624-1110 should be contacted to confirm whether prior authorization is required and to verify member eligibility.

Procedure: _____ CPT4: _____ DX/ICD-10: _____

Anticipated Date of Service: _____ (MM) / _____ (DD) / _____ (YYYY) Facility/Location: _____

Authorization Status:

Approved: _____ Auth #: _____ *Expiration Date: _____ (MM) / _____ (DD) / _____ (YYYY) Date Authorization completed: _____ (MM) / _____ (DD) / _____ (YYYY)

Denied: _____ Reason: _____ By: _____ Ext: _____

Pended: _____ For additional medical information ☐ For medical Review ☐ Information take By: _____ Date: _____ (MM) / _____ (DD) / _____ (YYYY)

Comments: _____

*** This authorization determines the medical necessity of the services requested based upon the information provided. It is NOT a guarantee of payment. It is issued subject to the terms and limitations of your agreement and the member's benefit plan, and subject to the member being eligible at the time services are provided. We reserve the right to deny reimbursement in the event of fraud or misrepresentation or if there is a material change in facts and circumstances that varies from the information that was provided with the original request.**

PLEASE ENSURE ALL PERTINENT CLINICAL INFORMATION IS ATTACHED.