

Fax Authorization Request Form

Neighbor
doing business as
HEALTH PROVIDERS



Suffolk Health Plan
EL PLAN DE SALUD SUFFOLK

Date of request: _____

Member Name: _____	
Member ID#: _____	_____
Medicaid# _____	DOB _____

STOP! CHECK SUFFOLKHEALTHPLAN.COM TO DETERMINE IF PRIOR AUTHORIZATION IS REQUIRED

FAX-800-338-4195

Requesting Provider: _____
Provider ID#: _____
Contact: _____
Phone: _____
FAX: _____

Request for Pre-Authorization

Authorization #:

For office use only

Please attach clinical information to demonstrate medical necessity for the requested service.

Diagnosis Code: _____ **Description**

Advanced Imaging

Please attach: brief summary of history, exam findings, diagnostic imaging results, relevant

Place of Service	Phone: _____	Fax: _____
Code Code Code	Notes	
<input type="checkbox"/> CT	_____	
<input type="checkbox"/> MRI	_____	
<input type="checkbox"/> PET	_____	
<input type="checkbox"/> Other:	_____	

Outpatient Services

Place of Service	Phone: _____	Fax: _____
<input type="checkbox"/> Orthotics	Procedure Codes	
<input type="checkbox"/> Prosthesis	_____	
<input type="checkbox"/> Medical Equipment	_____	
<input type="checkbox"/> Home Care	_____	
<input type="checkbox"/> Referral to Non-Par Provider	Notes	
<input type="checkbox"/> Formulary Overrides (CHP Only)	_____	
<input type="checkbox"/> Other Services	_____	

Elective Admissions ONLY

Scheduled Date	_____	Facility	_____
			Notes:

Procedures:			_____
Procedure Codes			_____

For Emergency admissions please fax notification to 800-338-4195

- √ For questions about the pre-authorization process please call Care Coordination at 800-250- 5007
- √ 5 business days Advanced Notice is Required

Care Coordination will fax an authorization letter to you when your request has been completed. If the service(s) is not approved a Care Coordinator will call you with the determination by telephone and in writing