NIVANO PHYSICIANS
High Quality • Easy Access

Nivano Physicians
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AUTHORIZATONS ARE VALID FOR 6 MONTHS FROM APPROVAL DATE
PHARMACY AUTHS ARE VALID FOR 3 MONTHS

AUTHORIZATION REQUEST FORM

Urgent –requires immediate action, although not life threatening ☐ **Routine** ☐ **Retro-DOS**_____

PATIENT NAME:	**DATE OF BIRTH:**	NAME OF GURANTOR :

ADDRESS:	CITY:	STATE:	ZIP CODE:	PHONE NO:

ATTACH ANY CONSULTATION, X-RAY REPORTS AND/OR ANY PERTINENT DOCUMENATION TO SUPPORT MEDICAL NECESSITY

MEMBER I.D. NO:	SUBSCRIBER NAME:

PCP:	REQUESTING PROVIDER:	CONTACT PERSON:	Phone # Fax #
TO PROVIDER: If unknown just not the specialty	**SPECIALTY:**	**CONTACT PERSON:**	Phone # Fax #

STREET ADDRESS (if out of network provider): CITY: ZIP:

Diagnosis ICD 10 code _____

☐ New Consult ☐ FOLLOW-UP VISIT
☐ OUTPATIENT SERVICE-FACILITY
☐ INPATIENT SERVICE-FACILITY

Name of Facility _____

CPT CODES

Σ AUTHORIZATIONS ARE SUBJECT TO ELIGIBILITY AND BENEFITS AT THE TIME OF SERVICE.
ANY SERVICES RENDERED BEYOND THOSE AUTHORIZED WILL BE SUBJECT TO DENIAL.

NIVANO USE ONLY

☐ APPROVED_____
☐ APPROVED AS MODIFIED_____

REVIEWED BY:	DATE:

☐ DEFERED FOR DOCUMENTATION_____
☐ DENIED