



## Authorization Request Fax Form

**FAX COMPLETED FORM TO:**  
**SSM Management Services**  
**FAX: (314) 989-2288 or 1-877-989-2288**  
**PHONE: (314) 989-2355 or 1-877-989-2355**

*For use by SSM Management Services*

**Auth #**

Date Processed: \_\_\_\_\_

**Issue Date**

To be completed by requestor

Instructions: This **CONFIDENTIAL** fax form is a request for authorization **ONLY**. **Request is NOT approved until an authorization number is assigned by SSM Management Services**. See Authorization Box above. The authorization number will be provided by fax or phone. **Use of par providers, par facilities and par ancillary providers is required**. Completion of this form is not a guarantee of payment. Reimbursement is limited to the benefits of the plan.

PATIENT INFORMATION - Print		EXCLUSIVECHOICE PROVIDER REQUESTED - Print	
First Name	Last Name	Physician First Name	Physician Last Name
ExclusiveChoice ID #	Patient Date of Birth	Specialty Type	Fax (     )
PRIMARY CARE PHYSICIAN INFORMATION - Print		Provider (if not physician)	
PCP First Name	PCP Last Name	Reason for Request:	
PCP Phone Number (     )	PCP Fax Number: (     )		
FORM COMPLETED BY - Print			
First Name	Last Name	Diagnosis (ICD-9) Code:	

NUMBER OF VISITS REQUESTED – Circle One	EXTENDED AUTHORIZATION REQUEST																		
<p>One Visit      Two Visits      Three Visits</p> <p>Other (Specify) _____</p> <p><b>NOTE: This request is for one visit when the number of visits is not specified. Authorization expires ninety (90) days from the Issue Date, regardless of number of visits authorized or used.</b></p> <p><b>Specialist should contact PCP to request an extension (90 days maximum).</b></p>	<table style="width: 100%;"> <tr> <td style="width: 50%;">6 Months</td> <td style="width: 50%;">12 Months</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Allergy</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Autoimmune deficiency</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chemo and/or radiation therapy</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Organ transplant/follow-up</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Renal Failure</td> </tr> </table> <p>Other: Contact SSM Management Services for other extended authorization conditions</p>	6 Months	12 Months		<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Chemo and/or radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant/follow-up	<input type="checkbox"/>	<input type="checkbox"/>	Renal Failure
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**SERVICES REQUESTED – CHECK ONE ONLY**

<input type="checkbox"/> Office Visit/Consult Only – No Diagnostic Testing	<input type="checkbox"/> Office Visit/Consult , Testing and Treatment/Surgery in Office
<input type="checkbox"/> Office Visit/Consult and Diagnostic Testing	<input type="checkbox"/> Office Visit/Consult, Testing and Surgery (facility inpatient or outpatient). Specialist must request authorization for surgery from SSM Management Services