



Authorization Fax Form

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.**

Patient/Member	First Name:		Middle Initial:	Last Name:	
	DOB (mm/dd/yyyy):			Gender:	Male Female
	Street Address:			Apt #:	
	City:		State:	Zip:	
	Home Phone:	Cell Phone:		Primary Contact:	Home Cell
	Health Plan:	Member ID:		Group ID:	
	Ordering Provider	First Name:			Last Name:
Primary Specialty:		TIN:	NPI:		
Physician Phone:			Physician Fax:		
Address:			Suite #:		
City:		State:	Zip:		
Office Contact:			Ext:		
Contact Email:					
Facility/Site		First Name:			Last Name:
	Group/Site Name:				
	Primary Specialty:		TIN:	NPI:	
	Site Phone:			Site Fax:	
	Address:			Suite #:	
	City:		State:	Zip:	
	Procedure	List all applicable CPT codes and modifiers:			
Diagnosis	Diagnosis, if known or rule out:				
	ICD-10 Codes:				
	Date of last visit:				

CONFIDENTIALITY NOTICE: This fax transmission, and any documents attached to it may contain confidential or privileged information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information is intended only for the use of the recipient (s) named above. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED. If you have received this transmission in error, please immediately notify eviCore healthcare and destroy the original transmission and its attachments without saving them in any manner.

Clinical Information

1. What is the requested site of service?

Inpatient

Office

Outpatient

Home

Observation

2. What is the anticipated date of service?

Medical documentation, including an exam narrative, office notes, results of diagnostic tests, and any equivalent notes must be submitted with this form. Additional information/comments: