LifeWorks ADVANTAGE

REQUEST FOR REFERRAL TO TELEHEALTH
REQUEST FOR PRIOR AUTH TO OTHER HEALTHCARE PROFESSIONAL & PSYCHIATRY

Call UM at 844-854-6883 (Call Center Hours M-F 8a– 8p) *FAX Form and Clinical to 833-610-2399*

**** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY*

***PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. (ATTACH OON FORM)** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

Member Data

Member Name ____________ **Date of Birth** ____________ **Member's Plan ID** ____________

Name of Nursing Facility ____________ **Referring Provider** ____________

Is Referring Provider: ☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request ____________

Service

Date of Procedure/Service: ____________ **CPT Code or Name of Procedure/Service**: ____________

SERVICES REQUESTED

Referral-include copy of order **PA-include clinical** **Out of Network- (ATTACH OON FORM)**

Psychiatry/HealthCare Professional

Provider Name (REQUIRED): ____________

Provider Contact Number (REQUIRED): ____________

Provider Specialty (REQUIRED): ____________

In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: ______

Telehealth

Vendor Name (REQUIRED): ____________

Vendor Contact Number (REQUIRED): ____________

Specialty (REQUIRED): ____________

In Network (REQUIRED): Circle Correct Answer: YES NO Number of Visits Requested: ______

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Name of Person Completing this Form: ____________ **(Please Print Name)** **Date Completed:** ____________

Contact #: ____________ **Contact FAX:** ____________