HIGHLINE MEDICAL SERVICES ORGANIZATION

"the right doctor for you"

REQUEST FOR SERVICE PRE-AUTHORIZATION

This authorization request form DOES NOT authorize payment for services in excess of those benefits currently provided under the member's coverage with their Health Plan. Payment is subject to eligibility and benefits at the time of service.

REFERRALS REQUIRED FOR:

- All **OUT** of HMSO Member Network Care
- Select **IN** HMSO member Network Care. See HMSO Prior Authorization Guide for list of select services/procedures/conditions that require prior authorization

Fax to HMSO prior to establishing service. Fax: (206) 878-1857

Today's Date	Name of Office Contact	Appointment Date

PATIENT INFORMATION

First Name _____

Last Name_____

Phone_____ Cell Ph_____DOB_____

Insurance ID _____

HMSO Managed Plan (circle one)

UHC UnitedHealthcare AARP Medicare Complete

UCP UnitedHealthcare Community Plan Apple Health

AMG Amerigroup Apple Health

HMSO REFERRING PROVIDER	REQUESTED CARE PROVIDER
	Name_____ Address_____ Phone _____Fax_____ Specialty_____

Diagnosis Code: _____ CPT Code (s): _____

Please check appropriate box : ☐ Standard ☐ Appointment Scheduled ☐ Urgent

Medical Necessity Information: (ATTACH ADDITIONAL CLINICAL TO SUPPORT REQUEST)

Number of visits requested_____

HMSO Provider Signature_____

The above signature is not an authorization.

DO NOT PROVIDE SERVICES UNTIL OFFICIAL AUTHORIZATION RECEIVED FROM HMSO.
THIS REQUEST DOES NOT CONSTITUTE A GUARANTEE OF PAYMENT.