

“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:
 Certain services and specialties require prior authorization from HMSO. See the HMSO Prior Authorization Guide for a list of services/procedures/conditions that require prior authorization. Access guide on www.hmsoinc.com
Fax to HMSO prior to establishing service. Fax: (206) 878-1539

Today's Date _____	Name of Office Contact _____	Appointment Date _____
PATIENT INFORMATION		
First Name _____	HMSO Managed Plan (circle one)	
Last Name _____	UHC UnitedHealthcare AARP Medicare Complete	
Phone _____ Cell Ph _____ DOB _____	UCP UnitedHealthcare Community Plan Apple Health	
Insurance ID _____	AMG Amerigroup Apple Health	

<u>HMSO</u> REFERRING PROVIDER	REQUESTED CARE PROVIDER
	Name _____
	Address _____
	Phone _____ Fax _____
	Specialty _____

Diagnosis Code: _____ CPT Code (s): _____

Please check appropriate boxes : Standard Appointment Scheduled Urgent

Number of visits requested: Eval 1 2 3

Note: Without the Specialists treatment plan, HMSO may only authorize up to 3 visits at a time.

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

 HMSO Provider Signature

The above signature is not an authorization.

**Please FAX Specialists consult reports/tests back to PCP timely.
 FAX any secondary Specialists consult recommendations or studies back to
 PCP to submit for prior authorization as applicable.**

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