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:

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) 834-6000

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 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.