

INSTRUCTIONS: Complete and submit the form below with relevant clinical notes and medical necessity information via email to commercialUMintake@mail.org. Once we receive this form, we will make a benefit determination within 5 days unless an expedited review is requested.

This request is (check one): **URGENT*** **NON-URGENT**

***Scheduling issues DO NOT meet criteria for "URGENT."**

IF you checked "URGENT" at left, please provide BOTH:

- Phone number of a person who can immediately discuss the case (not a general office number or answering service):

Immediate Contact Area Code/Ph #

- A medical provider's written explanation detailing how/why the usual decision days would:
 - Jeopardize the life or health of the member; and/or
 - Threaten the member's ability to regain maximum function; and/or
 - Subject the member to severe pain and inadequate management of the member's medical condition; and/or
 - Subject the member to severe pain that could not be adequately managed without the requested services.

Today's Date

Dates of Service

to

Contact Name

Email

Ph #

Fax#

PATIENT INFORMATION

Patient Name

Date of Birth (mm/dd/yr)

City/State

Primary Health Insurance

ID#

Plan

Other Health Insurance

ID#

Plan

PROVIDER INFORMATION

Requesting Provider

NPI#

Area Code/Ph#

Complete Address

Service Provider

NPI#

Area Code/Ph#

Complete Address

Tax ID#

Service Facility

Inpatient

Outpatient

Office

Home

Other

If other, please specify:

Complete Address

Tax ID#

Area Code/Ph#

Service Facility NPI

REQUESTED PROCEDURES AND/OR SERVICES

If you need more codes authorized, please attach a separate form.

Diagnosis Code	CPT/HCPCS Code	# Units/ Visits	DME Purchase Price	Procedure/Device Description*

* If hardware and/or implant will be used, please provide brand and model # in the relevant procedure/device description (last column in the above table).

Anesthesia Yes No
If yes, specify type Local Conscious Sedation General

Assistant Surgeon Yes No If yes, assistant surgeon name/NPI:

Surgical Approach Open Laparoscopic Endoscopic Robotic Other
If other, please specify

Will a computerized navigation system be used? Yes No N/A

If this request is for PT, OT, or ST, please indicate the number of visits for each type

Rehabilitative visits Habilitative visits Visits already used

DOCUMENTATION SUBMISSION

Submit completed form with relevant clinical notes and medical necessity information via email to commercialUMintake@imail.org.

Questions? Contact our member service phone line at 800-207-1018, Monday through Friday from 8:00 a.m. to 5:00 p.m.
Learn more at simplifiedbenefitsadministrators.org.