



COX HEALTHPLANS

CoxHealth

MEDICAL MANAGEMENT
P.O. BOX 5750
Springfield, MO 65801-5750
Toll Free # 1-800-205-7665
Local: 417-269-2813
Fax #: 417-269-2919

Medical Authorization Form

Please Type or Print Clearly. Form Must Be Filled Out Completely Prior to CHP Review.

| | |
|---------------|--------------------|
| Today's Date: | Form Completed By: |
|---------------|--------------------|

1. PATIENT INFORMATION

| | | | | | |
|--------------------|--------|---------|--------------------------|---|----------------------------------|
| Patient Name Last: | First: | Middle: | DOB (mm/dd/yyyy): / / | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | 11-Digit Patient Insurance ID #: |
|--------------------|--------|---------|--------------------------|---|----------------------------------|

2. MEDICAL SERVICE REQUESTED

| | | | |
|---------------------|-------------------|---------|-----------------|
| Referring Provider: | Phone #: () - | Ext. #: | Fax #: () - |
|---------------------|-------------------|---------|-----------------|

(Please Indicate):

1. Outpatient 2. Inpatient 3. Partial 4. Other:

| | | | |
|---|-------------------|---------|-----------------|
| Hospital/Facility/or Provider of Service: | Phone #: () - | Ext. #: | Fax #: () - |
|---|-------------------|---------|-----------------|

Rendering Hospital/Facility/or Provider -*Physical Address (*Required to Determine Benefit):

| | | | |
|--------|---------|------------|---|
| City*: | State*: | Zip Code*: | Tax ID# for Billing* (Required): |
|--------|---------|------------|---|

| | | | |
|--------------------------------------|----------------------------|---------------------------------|-------------------------------|
| Admission Date* (mm/dd/yyyy): / / | # of Days/Units Requested: | Start Date (mm/dd/yyyy): / / | End Date (mm/dd/yyyy): / / |
|--------------------------------------|----------------------------|---------------------------------|-------------------------------|

Diagnosis (ICD-10 Code) With Description (**Required**): (not for Clinical/Medical Records. Attach separately.):

Procedure Code (CPT Codes) With Description (**Required**):

3. COX HEALTHPLANS USE ONLY

| | | | |
|------------------|---------------------------------|-------------------------------|-------------------------|
| Authorization #: | Start Date (mm/dd/yyyy): / / | End Date (mm/dd/yyyy): / / | Service (s) Authorized: |
|------------------|---------------------------------|-------------------------------|-------------------------|

Comments:

Disclaimer:

This authorization is not a determination of benefits or a determination or guarantee of benefit payment, which are subject to a final verification of member eligibility. The authorization is limited to the specific services requested above. The member is responsible for the payment of services received during any period member is ineligible for coverage. CHP reserves the right to determine payment for any services received based upon the contractual rights of the member. CHP may also retract any authorization, or deny the benefits related to that authorization, if any authorization information is misrepresented. Benefit payments are still subject to industry coding standards and to investigation for potential exclusion as workers' compensation benefits.

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