
PHONE: 844-806-8217 Opt 3 FAX: 844-873-3163

# Additional Information

*****Please use this form when sending additional information or updated clinical*****

| | |
|---|---|
| | Today's Date: |
| Person to contact for this Submission: | Phone: |

| **Member Name:** | **Date of Birth:** | **Member ID Number:** |
|---|---|---|
| | | |

| **Authorization Number:** | |
|---|---|

**Check One**

| | |
|---|---|
| | Additional Information for an Outpatient Procedure |
| | Additional Information for an Inpatient Procedure |
| | Additional Information for an Inpatient Admission (Hospital) |
| | Additional Information for a Home Health Request |
| | Additional Information for a DME Request |
| | Additional Information SNF/LTACH/IRF |
| | Other: |

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to www.htanc.com for specific codes requiring a prior authorization.