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Authorization Request Form

Please complete this form and attach supporting clinical documentation. For fax numbers and frequently asked questions, visit **https://www.coherehealth.com/provider/resources**

Don't want to fax anymore? You could be getting time-saving benefits, including immediate auth decisions and guided submissions by using the portal. Registration only takes a few minutes, and unlocks access for all users at your organization. **Visit www.coherehealth.com/register to begin.**

Patient information

Patient first name **required*	Patient last name **required*
Member ID **required*	Date of birth (MM/DD/YYYY) **required*

Requestor information

Requestor first name **required*	Requestor last name **required*
Requestor email **required*	Requestor phone number **required*
Requestor fax number **required*	Requestor type (please ☒ one of the following options) **required* ☐ Ordering provider ☐ Performing provider ☐ Facility

Diagnosis codes

Primary diagnosis code **required*	Secondary diagnosis code	Secondary diagnosis code

Service details

Care setting (please ☒ one of the following options) **required*

☐ Inpatient ☐ Outpatient

Start date (MM/DD/YYYY) **required*	End date (MM/DD/YYYY)

Place of service (please ☒ one of the following options) **required*

☐ Ambulatory Surgical Center	☐ On Campus-Outpatient Hospital
☐ Comprehensive Outpatient Rehabilitation Facility	☐ Observation- Off Campus Outpatient Hospital
☐ Comprehensive Inpatient Rehabilitation Facility	☐ Observation- On Campus Outpatient Hospital
☐ Home	☐ Skilled nursing facility
☐ Office	☐ Inpatient Hospital
☐ Off Campus-Outpatient Hospital	☐ Other _____

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Procedure codes **The Details (modifiers) field is only required for some procedure codes.*

CPT/HCPCS code 1	Details (modifiers)* ☐ Left ☐ Right ☐ Bilateral	Units *required	CPT/HCPCS code 2	Details (modifiers)* ☐ Left ☐ Right ☐ Bilateral	Units *required
CPT/HCPCS code 3	Details (modifiers)* ☐ Left ☐ Right ☐ Bilateral	Units *required	CPT/HCPCS code 4	Details (modifiers)* ☐ Left ☐ Right ☐ Bilateral	Units *required

Procedure codes (DME) **The Details (modifiers) field is required for DME codes*

CPT/HCPCS code 1	Details (modifiers) *required ☐ Rental ☐ Purchase	Units *required	CPT/HCPCS code 2	Details (modifiers) *required ☐ Rental ☐ Purchase	Units *required
CPT/HCPCS code 3	Details (modifiers) *required ☐ Rental ☐ Purchase	Units *required	CPT/HCPCS code 4	Details (modifiers) *required ☐ Rental ☐ Purchase	Units *required
CPT/HCPCS code 5	Details (modifiers) *required ☐ Rental ☐ Purchase	Units *required	CPT/HCPCS code 6	Details (modifiers) *required ☐ Rental ☐ Purchase	Units *required

Ordering provider

Name *required		Street address
City	State	Zip code
National Provider Identifier (NPI) *required		Taxpayer Identification Number (TIN) *required
Fax number - -		Phone number - -

Performing or attending provider

Is performing provider the same as the ordering provider? If so, please ☒ Yes and leave below section blank. ☐ Yes ☐ No

Name *required		Street address
City	State	Zip code
National Provider Identifier (NPI) *required		Taxpayer Identification Number (TIN) *required
Fax number - -		Phone number - -

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Performing facility or agency

Name **required*		Street address
City	State	Zip code
National Provider Identifier (NPI) **required*		Taxpayer Identification Number (TIN) **required*
Fax number		Phone number

Additional care participant

Additional care participant refers to organizations such as drug suppliers, DME vendors, and clinics. Please note that this is only applicable to some services.

Name **If applicable*		Street address
City	State	Zip code
National Provider Identifier (NPI) **required*		Taxpayer Identification Number (TIN) **required*
Fax number		Phone number

Expedite request

☐ Expedite this request	In order for a case to be expedited the physician (or other clinician) must indicate that applying the standard timeframe could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. If the date of service is greater than 3 days in the future, please DO NOT submit this request as expedited.
Please provide physician (or other clinician) justification	
Physician (or other clinician) signature	

Have a question about this form?
visit https://www.coherehealth.com/provider/resources

Fax forms are updated periodically to reflect the most recent authorization requirements
visit our website for the latest version.

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HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

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