Medicare authorization

SUMMIT HEALTH

This form may be returned unprocessed if not completely filled out with all requested information. Authorizations will be given for medically necessary services only. This request cannot be processed without supporting documentation.

☐ Referral
☐ Inpatient
☐ Outpatient

☐ **Standard authorization** *(Completed within **14 days** of receipt.)*

☐ **Expedited** *(**Choose ONLY if** you are attesting that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Completed within **72 hours** of receipt.)*

Section 1 Patient information

Patient name	Date of birth	Member ID no.
Insured name	Group no.	

Section 2 Requesting provider (PPO plans) primary care provider (HMO plans) information

PCP/on-call doctor		TIN/NPI
Phone	Fax	Contact

Section 3 Servicing provider or specialist information

Specialist name		TIN/NPI
Phone	Fax	Contact

Section 4 Facility information

Facility		TIN/NPI
Phone	Fax	Contact
Admit date	Discharge date	

Section 5 Service requested

Planned date of service from	to	Schedule date (if known)
ICD-code (primary)		Description
ICD-code (additional)		Description

CPT-4/HCPCS code	Description of procedure or service	Visits/frequency
Comments		

Ready to submit? Fax to 855-637-2666 or mail to
Summit Health, Attn: Medicare Authorization Department, P.O. Box 820070, Portland, OR 97282
Questions? Call us toll-free at 844-931-1778.