



## PRIOR AUTHORIZATION REQUEST FORM

Submit this completed form by fax to **1-833-610-2399**, or on our provider portal:  
<https://secure.healthx.com/LagniappeAdvantage.Provider>  
 Call 1-844-217-0052 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless it is an emergency, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

- Routine/Standard     
  Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION			
Member Name:	Member ID:		
Date of Birth:	Member Residence:		
REQUESTING PROVIDER/FACILITY			
Requestor's Name:	Phone Number:	Fax Number:	Date of Request:
Referring Provider (If other than requestor):	Referring Provider: <input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other		
SERVICING PROVIDER/FACILITY			
Admitting/ Servicing Facility/ Provider Name:			
NPI/ TIN Number:	Phone Number:	Fax number:	
Address:			
City:	State:	Zip:	
SERVICE TYPE REQUESTED			
<input type="checkbox"/> Initial Request <input type="checkbox"/> Extension Request, Previous Auth #:			
Outpatient Services (Select one):			
<input type="checkbox"/> Durable Medical Equipment (DME) <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Imaging/Special Tests <input type="checkbox"/> Office Procedures	<input type="checkbox"/> Laboratory Services <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation	<input type="checkbox"/> PT/OT/ST <input type="checkbox"/> Wound Care <input type="checkbox"/> Part B Medication <input type="checkbox"/> Behavioral Health Services <input type="checkbox"/> Other	
Days/ Visits/ Units Requested:		Admission Date/ Date of Service:	
CPT/HCPCS Code(s):			
Current Primary Diagnoses and ICD-10 Code (s):			

**CLINICAL INFORMATION**

- Please submit written documentation from the medical record to support the procedure, including photos when applicable.
- Missing this information may delay the decision on your request or may result in Lack of Information denial.
- Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.

**OUT-OF NETWORK SERVICES ONLY**

- Has the service been scheduled already?  Yes  No
- Is this a specialized service that no other In-network provider can render?  Yes  No
- Does the member have an established relationship with the provider that should not be interrupted?   
Yes  No  
If "Yes", explain (include last visit date):