Telephone: (866) 679-1647
Fax: (212) 908-5185

Integra Partners Utilization Management

METROPLUSHEALTH AUTHORIZATION REQUEST FORM

Date: ______________________

PATIENT INFORMATION:

Full Name: ______________________________________ DOB: ______________________

ID #: ______________________

POLICYHOLDER INFORMATION:

Full Name: ______________________________________ DOB: ______________________

ID #: ______________________

Other Insurance: ______________________________ Is other insurance primary? ☐ Yes ☐ No

ORDERING PHYSICIAN INFORMATION:

Full Name: ______________________________________ Phone: ______________________

NPI #: ______________________________________ Fax: ______________________

Address:

____

City/State: ______________________________________ Zip: ______________________

SERVICING PROVIDER/VENDOR INFORMATION:

Full Name: ______________________________________ Phone: ______________________

NPI #: ______________________________________ Fax: ______________________

Address:

____

City/State: ______________________________________ Zip: ______________________

Contact Name: ______________________________________ Phone: ______________________

Patient Name: ____

Is this an Urgent Request? ☐ Yes ☐ No

If yes, indicate why: ☐ Hospital discharge/SNF ☐ Need within 24 hrs. to avoid serious harm/impairment

Diagnoses: ____

Was member serviced? ☐ Yes ☐ No If so, indicate date of service:____________________

HCPCS Code	**Service Description Include Manufacturer Name and Model Number for NOC Services**	**Quantity**	**Rental (RR) or Purchase (NU)?**	**Date of Service Start**	**Date of Service End**

Additional Details (if necessary):

NOTE: Incomplete Authorization Request forms will be returned and may delay the processing of your request. Thank you.