

Authorization Request

Fax this form with **all pertinent clinical** information to Medical Management at: **918-878-5900** or **1-800-594-0105**
Clinical information (such as previous diagnostic testing, medications, etc.) should accompany this request to determine medical necessity. Failure to submit pertinent, supporting documentation can result in the request being denied.

Contact Name:					Date:		
Phone Number:					Fax Number:		
☐ By checking this box, I certify that the phone number and fax number listed above are accurate, secure, and confidential.							
Patient Name:					Date of Birth (DOB):		
ID Number:					Patient Phone Number:		
Ordering Physician:					NPI #		
Phone Number:					Fax Number		
Type of Service/ Service Category:	☐	Office Visit	☐	Diagnostic Testing	☐	DME	☐
	☐	ER/Urgent Care	☐	Observation	☐	Inpatient Rehab	
	☐	Outpatient Procedure			☐	Clinical Registry	
	☐	Inpatient Procedure					
	☐	Special Injectables/Medications - <i>if this request is for a Special Injectable/ Medication please fax to our Pharmacy Help Desk at 918-879-4309 or call 918-594-5211.</i>					
	☐						
	☐	Other:					
Priority:	☐	Urgent	☐	Routine			
Quantity:			Dates of Service(s):			☐	To be determined
Servicing Provider/Facility:					Tax ID #:		
Diagnosis Code(s):					CPT Code(s):		
Diagnosis(es):					Procedure(s):		
Remarks/Additional Information:							

Please fill out this form completely. Questions? Call Medical Management at 918-594-5228 or 800-594-0089

Authorization means that CommunityCare has determined the requested service are medically necessary and appropriate. This authorization does not guarantee payment. The member must be eligible on the date the service is rendered for this authorization to be valid. CommunityCare does not guarantee eligibility for patients covered by a group health plan or any Medicare plan, but relies on eligibility information provided to it by the employer or CMS. Payment is subject to benefit plan limits. The patient is financially responsible for the cost of the authorized services received if he/she is determined ineligible for coverage or exceeds benefit plan limits. information provided to it by the employer or CMS. Payment is subject to benefit plan limits. The patient is financially responsible for the cost of the authorized services received if he/she is determined ineligible for coverage or exceeds benefit plan limits.