Alliance Coal Health Plan

PREAUTHORIZATION REQUEST FORM

Prior to faxing, please verify benefits with Member Services via Provider portal: secure.heatlhx.com/alliance.provider OR via phone (855) 979-5192

This request is: ☐ **Routine**
☐ **Urgent**
☐ **Retro Auth Request**

Fax to: (844) 230-8727 **Telephone: (855) 979-5194**

A. PROVIDER CONTACT INFORMATION (Failure to provide may result in delays)

Any questions regarding this request should be directed to:

_____ _____ _____
Contact Name** Phone Number** Fax Number**

B. MEMBER INFORMATION

_____ _____ _____
Alliance Coal Member ID** Patient's Name (Last, First, MI) ** DOB**

C. ICD-9-CM/ICD-10-CM DIAGNOSIS CODE(S)

Diagnosis Code(s)**: _____ _____ _____ _____

D. PROCEDURE/SERVICE/TREATMENT INFORMATION

Place of Service**: ☐ Inpatient ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Lab/Diagnostic Svcs ☐ Office ☐ Home

CPT/HCPCS Code(s)**: _____ _____ _____ _____

Name of Facility Performing Procedure/Service/Treatment**: _____

Date of Service: _____ ☐ Not yet scheduled Number of Visits/Units Requested**: _____

E. PROVIDER INFORMATION

_____ _____
Requesting Physician Name** NPI **

_____
Mailing Address**

_____ _____
Phone Number** Fax Number

_____ _____
Facility** NPI**

_____
Billing Address**

_____ _____
Phone Number** Fax Number

Clinical information attached: ☐ No ☐ Yes - # of pages _____
**REQUIRED INFORMATION

To avoid delays, please attach all clinical documentation to support your request

If this treatment is currently classified as experimental, investigational, part of a clinical trial, or a benefit exclusion then it may not be a covered benefit.

Approval of this request does not guarantee payment.