# Authorization Request Form

Please complete form in its entirety and return to **CorporateMedicaidCIT@humana.com** (email) or **1-833-974-0059** (fax).

Date of request:

| Member information | | |
|---|---|---|
| Medicaid ID: | Humana ID: | Date of birth: |
| Last name: | First name: | |

| Requesting provider/facility | | |
|---|---|---|
| Provider name: | TIN: | NPI: |
| Address: | City, State, ZIP: | |
| Contact name: | Phone: | Fax: |

| Treating/servicing provider | | |
|---|---|---|
| Provider name: | TIN: | NPI: |
| Address: | City, State, ZIP: | |
| Contact name: | Phone: | Fax: |

**Authorization type**

☐ Medical ☐ Inpatient acute ☐ Inpatient standard ☐ Outpatient standard ☐ Urgent/expedited

Authorization begin/admission date: Authorization end/discharge date:

| | | | |
|---|---|---|---|
| ☐ C-section delivery | ☐ Observation | ☐ Premature labor | ☐ Surgery |
| ☐ DME | ☐ Outpatient surgery | ☐ Rehabilitation | ☐ Therapy services |
| ☐ Home health | ☐ Personal care services | ☐ SNF | ☐ Vaginal delivery |
| ☐ NICU | | | |

**Diagnosis/procedure codes**

Primary ICD-10 code: Additional ICD-10 codes:

| | | | |
|---|---|---|---|
| CPT code: | Number of units requested: | CPT code: | Number of units requested: |
| CPT code: | Requested units: | CPT code: | Number of units requested: |

Additional information:

**Note:** In order to process your authorization request, submit all necessary documentation supporting medical necessity.

**Disclaimer:** An authorization does not guarantee payment by Humana. Responsibility of payment shall be subject to membership eligibility, benefit limitations and medical necessity.

Humana Healthy Horizons® in Louisiana



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