

MEMORIAL INTEGRATED HEALTHCARE

MIH--AUTHORIZATION FORM

PROVIDER REQUEST DATE _____ START OF CARE DATE _____
AUTH/REFERENCE # _____ AUTH END DATE _____
SCHEDULED ADMISSION/SURGERY/PROCEDURE DATE: _____
PT/HH/DME: APPROVED FOR ___ VISITS ___ WEEKS ___ UNITS
VALID FOR: 30 60 90 120 DAYS 6 MONTHS
PROVIDER OFFICE REP: _____ MIH NURSE _____

AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT

APPROVED

DENIED (LTR TO FOLLOW)

MIH FAX NUMBERS: PSN: 954-967-7592 MMCP/PCC 954-967-7591 CMS: 954-967-7593	REQUESTING TO PROVIDER:	
MIH PHONE NUMBER: 954-276-3131	REQUESTING FROM PROVIDER NAME:	
PCP NAME:	PCP PHONE #:	PROVIDER FAX NUMBER:
MEMBER NAME:	D.O.B.:	PROVIDER PHONE NUMBER:
MEMBER ID NUMBER: (FOR PCC USE MEDICAL RECORD #)	PROVIDER TAX ID NUMBER:	

PRODUCT LINES:

<input type="checkbox"/> CMSN-SE FLORIDA REGION T-19 T-21 WPB-21 CHILDREN'S MED. SERVICES	<input type="checkbox"/> R-SFCCN/ PSN MHS SOUTH FLORIDA COMMUNITY CARE NETWORK	<input type="checkbox"/> PCC / UPFUND PRIMARY CARE / UNINSURED PATIENT FUND	<input type="checkbox"/> MMCP MEMORIAL MANAGED CARE
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ROUTINE (PROCESS WITHIN 3 BUSINESS DAYS)

URGENT (PROCESS WITHIN 24 HOURS)

EMERGENT (PROCESS WITHIN 4 HOURS)

NON-PARTICIPATING (OON REQUIRES AUTH)

Reason for request: (Attach pertinent medical records to assist in authorization)

Diagnosis _____ ICD-9 _____
Procedure _____ CPT-4 _____ HCPCS _____
Comment _____

Place of Service: 11 (Office) 21 (IP Hospital) 62 (OP Physical Therapy) 24 Amb Surg Ctr

12 (Home) 22 (OP Hospital) Other _____

Facility /Provider's name where service to be performed: MRH MHW MHP MHM MRHS

Other _____ Provider's Name _____

Provider's Signature _____ Date _____ Provider's Printed Name _____

Please send your claims to: For CMS/PSN/MMCP - P.O. Box 849029, Pembroke Pines, FL 33084
For PCC/Upfund - P.O. Box 849119, Pembroke Pines, FL 33084

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