Horizon Blue Cross Blue Shield of New Jersey

Date of Request: _____

In place of this Form you can submit Authorization Requests Online securely via Navinet. If you are not registered, please visit Navinet.net and click *Sign Up* or call Navinet Customer Care at **1-888-482-8057.**

Cardiac/Pulmonary/Cognitive/Nutritional Therapy Authorization Request Form

Requirements: *Clinical information and supportive documentation should consist of office visit notes and recent diagnostic. Test results must be submitted to support request for approval.* ***Notification required for any date of service change. Please complete this form in its entirety, in order to prevent processing delays.***

Fax completed form to: Horizon NJ TotalCare (HMO SNP) at **1-609-583-3013**

General Information

Member Name:_____ **Member ID #:**_____ **DOB:**_____

Provider Contact Name:_____ **Phone #:**_____ **Fax #:**_____

List Any Additional Insurance:_____

Policy Name/Number:_____

Medical Information Needed

Date/Date Range of Service:_____

Days/Units Requested:_____

Primary Diagnosis: _____ **Other Chronic Diagnosis:**_____

ICD 10 Codes: _____

Procedures(s) Requested:_____

CPT Codes Requested:_____

Requesting Provider:_____ **ID# & NPI#:**_____ **TIN#:** _____

Servicing Facility: _____ **ID# & NPI#:**_____ **TIN#:** _____

Location of Service: **Home** **Hospital** **Other** _____

Additional Required Information

Cardiac Therapy

- **Type of cardiac event: (MI, CABG, angioplasty, heart valve, transplant surgery)** _____
- **Date of cardiac event:**_____ **Name of treating physician:**_____

Pulmonary Therapy

- **Reason for therapy (LVRS, COPD, Cystic Fibrosis, interstitial pneumonitis, thoracic deformities, pre/post lung Transplant)**_____ **Name of treating pulmonologist:**_____

Cognitive Therapy

- **Reason for therapy: (Head Injury, Other Neurological Disorders)** _____

Nutritional Therapy

- **Name of "medical food" or "low protein modified food product":** _____