Horizon Blue Cross Blue Shield of New Jersey

Date of Request:_____

Non-Par Physician Authorization Request Form

Requirements: *A letter of medical necessity for services by a non-participating provider/physician is required. Please be specific as to why a par provider/physician cannot provide this service.* ***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:**_____

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

Member Address:_____ **Member Phone #:**_____

List Any Additional Insurance:_____ **Policy Number:**_____

Medical Information Needed

Date/Date Range of Service:_____ **#Days/Units Requested:**_____

Primary Diagnosis:_____ **ICD 9 Codes:** _____ **ICD 10 Codes:** _____
(ICD 9 Codes active until 9/30/14)

Other Chronic Diagnosis:_____ **ICD 9 Codes:** _____ **ICD 10 Codes:** _____

Procedures(s) Requested:_____

CPT/HCPCS Codes Requested:_____

Requesting Provider:_____ **ID# or NPI#:**_____

Additional Required Information

Servicing Provider Name: _____ **Specialty:** _____

Group Practice Name: _____

Tax ID# _____ **NPI#:**_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Billing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Treatment Setting: **MD Office** **Outpatient Hospital** **Hospital SPU/OR** **Other**

Non-Par Contact Person:_____ **Phone #:** _____ **Fax#:** _____

- **Do you accept Medicaid/DSNP rates? Yes No Is this for continuity of care? Yes No**
  If yes, please fax to Horizon NJ TotalCare (HMO SNP) the most recent visit and plan of care and test results with this form.
- **Timeframe this non-par provider/physician has been treating this member:**_____
- **Is surgery anticipated? Yes No If yes, where will surgery be done:**_____
  Expected date:_____
- **Has there been any surgery performed by this provider/physician for this member in the past? Yes No**
- **Affiliated with par hospital? Yes No Hospital Name:** _____