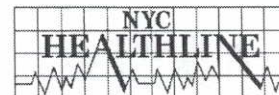


NYC Healthline Fax Authorization Request
Medical Management
Fax 1-800-241-5308

For City of New York Employees and non-Medicare eligible retirees
(Group numbers 157000-157699)



An Anthem Company



Member/Subscriber information

Last name	First name	ID no.
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Patient information

Last name	First name	Date of birth (MMDDYYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Relationship to Member/Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			

Authorization requested from the NYC Healthline for: (check one service per fax form) ☐ Emergency ☐ Scheduled

<input type="checkbox"/> Inpatient acute <input type="checkbox"/> Inpatient rehabilitation <input type="checkbox"/> Maternity <input type="checkbox"/> NICU <input type="checkbox"/> Skilled nursing facility	<input type="checkbox"/> Ambulatory surgery <input type="checkbox"/> Air ambulance <input type="checkbox"/> Cardiac rehabilitation <input type="checkbox"/> DME or prosthetics <input type="checkbox"/> Genetic testing	<input type="checkbox"/> Infertility service <input type="checkbox"/> Outpatient therapy: <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> Radiology therapy <input type="checkbox"/> Specialty drugs		
Admission date (MMDDYYYY)	Requested length of stay _____ days	First date of service (MMDDYYYY)	No. of visits requested	Authorization period requested _____ days
Additional services continue to require precertification by EmblemHealth. Providers should call 1-800-223-9870 for precertification.				

Diagnosis/Procedure information

Primary diagnosis	ICD-10 code
Secondary diagnosis	ICD-10 code
Procedure	CPT-4 code

Facility/Provider information

Name	NPI
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Physician information

Name of ordering physician	Provider NPI no.		
Phone no.	Fax no.		
Street address	City	State	ZIP code

Fax request submitted by: Name	Fax no. (if different than above)
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For Empire use only

Authorization Status:	
<input type="checkbox"/> Approved: LOS authorized: _____ Authorization no.: _____	OR No. of visits: _____ for period of: _____ days authorized *Date authorization completed: _____
<input type="checkbox"/> Denied: By: _____	Phone no.: _____
<input type="checkbox"/> Pended: For Additional medical information: _____	For medical review: _____
Comments: _____	
* This authorization is based upon medical necessity, subject to the terms and conditions of the member's contract and is NOT a guarantee of payment.	