Valor Health Plan

Insurance focused on you.

Authorization Request Form Attn: Intake Processing Unit
To verify benefits: 1-800-485-3793
To check status of a request: 1-844-228-1070
Fax Request To: 1-844-798-4357

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

Authorization Type: (check one) ☐ Standard ☐ Urgent / Expedited

Date: ____/____/____ *Check here if request is in response to a denied claim* ☐

Member Name: _____

Member Number: **VL**_____ Date of Birth: ____/____/____

Prescribing Provider: _____

Servicing Provider/Facility Name: _____

Phone: _____ Fax: _____

Request Service: Inpatient Admissions **Service Dates:** _____

☐ Acute Inpatient Hospital Admission ☐ Psychiatric Inpatient Admission

☐ Skilled Nursing Admission ☐ Inpatient Rehab Admission

Request Service: Outpatient Services **Service Dates:** _____

☐ Physical Therapy ☐ Durable Medical Equipment

☐ Occupational Therapy ☐ Ambulatory / Outpatient Surgery

☐ Speech Therapy ☐ Home Health

☐ Diagnostic Services ☐ Radiology Services

☐ **Out of Network Inpatient or Outpatient Services**

ICD_____ Diagnosis Descriptions _____

Service Code (CPT,HCPCS,etc.) _____ Service Descr._____

Quantity/Frequency/Duration (as applicable): _____

☐ **Clinicals are attached to support request. (All applicable clinicals should be attached.)**

For Questions Regarding this Request, Contact:

Name: _____

Phone: _____ Fax: _____

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