OVATION HEALTH
THE FUTURE OF HEALTHCARE

General Medical and Surgical Authorization Request

All Prior Authorization requests must be signed and all fields are required and must be complete. Incomplete requests will be returned. Please include all supporting medical documentation, and include the Member ID number on all pages.

Submit the completed form via Secure Fax to **866-234-8707** or by Email to **Authorizations@ovation-health.com**.

Date Requested _____ Request by _____

Phone _____ Fax Number _____

Member ID# *(As appears on card)* _____ Group # _____

Member/Patient Name _____

Patient's Date of Birth _____ Date of Office Visit _____

Provider/Facility Name _____

Provider/Facility NPI Number _____

Provider/Facility Tax ID _____

NOTE: Up to five procedure (CPT/HCPCS/RCC) codes may be entered. An additional form can be completed if extra space is required. CPT codes not reported on this or attached form(s) will be subject to medical review for payment.

Date of Service		**Procedure CPT/HCPC/RCC**		**Unit/Days Requested**
From	To	Code	Modifier	Units / Days

We attest that any exam, treatment, and/or procedure for the patient named above are **medically necessary** and will submit our claim electronically to **EDI# 20510** as soon as possible.

We agree to accept the reimbursement of 100% plan allowable rates for the county in which these services or procedures are rendered and reported. Clean claims will be paid within **30 days of receipt** per Texas State regulations.

NOTE: This Authorization Request does not ensure eligibility and does not guarantee payment for the services listed upon signing.

Signature/Initial: _____ Date: _____

Print Name: _____

SUBMIT FORM