PRE-SERVICE/ PRIOR AUTHORIZATION REVIEW REQUEST FORM

LifeWise of WA fax to: 800-843-1114
(FORM MUST BE THE FIRST 2 PAGES OF SUBMISSION AND NOT HANDWRITTEN.)

LifeWise
Health Plan of Washington

Request date: _____

MEMBER/PATIENT: _____ Date of birth: _____
Member ID: _____ Suffix: _____ Group #: _____

REQUESTING PROVIDER: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
Contact person: _____
Tax ID (**required**):_____
NPI # (**required**): _____

☐ **CHECK HERE IF THE SERVICING PROVIDER IS THE SAME AS THE REQUESTING PROVIDER.**

SERVICING PROVIDER: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
Contact person: _____
Tax ID (**required**):_____
NPI # (**required**): _____

REQUIRED: Complete all fields that apply for place of service. To enable Site of Service boxes download form before completing

FACILITY: _____
Address: _____
City: _____ State: _____ ZIP: _____
Tax ID (**required**):_____
NPI # (**required**): _____
Phone: _____ Fax: _____

☐ Outpatient hospital
☐ Inpatient hospital
☐ Office
☐ Ambulatory surgical center
☐ Freestanding Infusion Center
☐ Ongoing treatment
☐ Home ☐ Other _____
* For medical and psychiatric lower levels of care, use our Admission/Concurrent Review Fax Form.

Date scheduled: _____ **Existing reference #:** _____ **Expiration date:** _____

☐ **URGENT REQUEST - PLEASE NOTE: Scheduling issues do not meet the definition of urgent.**
Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: _____

CLINICAL INFORMATION required. Attach supporting medical records and include presenting symptoms and previous treatment.

Procedure code/CPT code:	Modifier: (LT/RT/NU/RR)	Units:	ICD diagnosis code:

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.