PHONE: 844-806-8217 Opt 3 FAX: 844-873-3163

Additional Information

*****Please use this form when sending additional information or Updated clinical*****

	Today's Date:
Person to contact for this Submission:	Phone:

Member Name:	**Date of Birth:**	**Member ID Number:**

Authorization Number:	

Check One

	Additional Information for an Outpatient Procedure
	Additional Information for an Inpatient Procedure
	Additional Information for an Inpatient Admission (Hospital)
	Additional Information for a Home Health Request
	Additional Information for a DME Request
	Additional Information SNF/LTACH/IRF
	Other:

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to www.htanc.com for specific codes requiring a prior authorization.