1199SEIU
Benefit and Pension Funds

National Benefit Fund (646) 473-9200 | Pension Fund • (646) 473-8666
Greater New York Benefit Fund • (212) 541-9150 | Pension Fund • (646) 473-8666
Home Care Employees Benefit and Pension Funds • (646) 473-9200
Home Health Aide Benefit Fund • (646) 473-7470

330 WEST 42ND STREET ■ NEW YORK, NY 10036-6977 ■ www.1199SEIUBenefits.org

Care Management Programs Department
Service/Equipment Request for Authorization

Fax completed form to (646) 473-7447.

Request Submitted By: ______________________________ Request Date: __________

Name of Ordering/Treating
Physician: ____

TIN # (Tax ID): ____________________ Referring MD Fax #: (______) ______ - ________

Name of Facility/Vendor Providing Service: ______________________________________

TIN # (Tax ID #): ____________________ Vendor Fax Number: (______) ______ - ________

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1199SEIU Member's Name: ______________________________

Member ID: | | | | | | | | | | |

Patient (if not member): ______________________________________

Patient date of birth: _____ / _____ / _____ Age: ______

Is Patient's Condition Related To:

Employment? (Current or Previous)	☐ No	☐ Yes	If yes, date ____________
Auto Accident?	☐ No	☐ Yes	If yes, date ____________
Other Accident?	☐ No	☐ Yes	If yes, date & type of accident ____________

Is legal action being taken? ☐ No ☐ Yes

Is there Other Insurance? ☐ No ☐ Yes List: ____________

♦♦

CPT/HCPCS Code(s) & Description ______________________________________
____

ICD-9 Code(s) & Description: ______________________________________
____

Member ID: | | | | | | | | | | Patient's Name: ___________________________________

Principal: ____

Secondary: ____

Complaints Pertinent to Request /Pertinent History/ Objective Findings/Date & Type of Surgery if Related to Request:

____

____

____

Prior Treatment/Medication Therapy & Outcomes:

____

____

____

Prior Diagnostic Studies & Results:

____

____

____

Projected Treatment Plan and Expected Outcome:

____

____

____

Comments:

____

____

____

Name of Ordering/Treating Physician: ____

Physician Signature: ______________________________________Date: _____ / _____ / ______

Physician Specialty: ____________________________ Telephone: (_______) _______ - ________

Office Address: ____

____

____

Name of Facility/Vendor Providing Service:

____

Address: ____

Vendor Authorized Signature: ____________________Print Name: ___________________Title: ________________________

Contact Person: ____ Title: ____

Telephone: (_________) _________ - ___________

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Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD-9 codes must be included.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446.

Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.