Allegiance
Benefit Plan Management

INPATIENT AND OUTPATIENT SURGICAL PROCEDURES
PRIOR AUTHORIZATION REQUEST

Please Return <u>this cover sheet</u> and <u>all required information</u> to: **Attn: _____**

Fax: (406) 523-3111

Phone: (800) 877-1122

Mail: **Allegiance Benefit Plan Management, Inc.**
P.O. Box 3018
Missoula, MT 59806-3018

Sent By: _____

COMPLETED BY ORDERING PHYSICIAN:

Patient Name:	Patient Health Plan ID #:	Patient Date of Birth:
Provider Name:	Provider TIN:	Provider Phone: Provider Fax:
Request Date:	Scheduled Date:	

Inpatient   Outpatient

Please provide the following information:
1. A complete description of the procedure(s) or treatment(s) for which pre-authorization is requested.
2. A complete diagnosis and all medical records regarding the condition that supports the requested procedure(s) or treatment(s), including, but not limited to, informed consent form(s) all lab and/or x-rays, or diagnostic studies;
3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;
4. The attending Physician's prescription, if applicable;
5. A Physician's referral letter, if applicable;
6. A letter of medical necessity;
7. A written treatment plan; and
8. Any other information deemed necessary to evaluate the pre-authorization request.

Upon receipt of all required information, the Plan will provide a written response to the written request for preauthorization. Please allow 3-5 business days for a response.