Fax

CareFirst

POST-ACUTE CARE AUTHORIZATION FORM	
To Utilization Management	From
Fax 410-505-2588	Office Phone
	Cell Phone
Date	Number of pages *(including cover sheet)*

Dear Provider,

Please complete all fields below and include all current (within past 24-48 hours) PT/OT/ST or pertinent clinical information for the requested service.

This is a concurrent request, a decision will be completed and communicated within 1 business day once all required information is received.

Member Name		CareFirst ID Number
Current Location of the Member		
Requested Level of Care		
Receiving Facility		
Date of Admission to Receiving Facility		
Primary Diagnosis/ICD10		
Attending Physician (Current or at Facility)		
Contact information for Receiving Facility (Name)		Phone
Address of Receiving Facility		
City	State	Zip Code

Confidentiality Notice

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