dell children's Health Plan

Prior Authorization Request Form

Dell Children's HealthPlan prior authorization: **1-855-962-4453** (phone); **1-844-981-3329** (fax).
To prevent a delay in processing your request, please fill out the form in its entirety with all applicable information.

Today's date:			**Provider return fax:**		
Member information					
First name:		Last name:		Date of birth:	
Dell Children's Health Plan member ID:			Contact phone:		
Address:			City, State ZIP code:		
Additional member information:					
Referring provider		**Participating:** ☐		**Non-participating:** ☐	
Full name:				NPI:	
Specialty:				Provider ID:	
Tax ID number (TIN):			Office contact name:		
Office phone:				Office fax:	
Address:			City, state ZIP code:		
Servicing provider		**Participating:** ☐		**Non-participating:** ☐	
Full name:				NPI:	
Specialty:				Provider ID:	
Tax ID number (TIN):			Office contact name:		
Office phone:				Office fax:	
Address:			City, state ZIP code:		
Servicing facility		**Participating:** ☐		**Non-participating:** ☐	
Name:					

Dell Children's Health Plan
1345 Philomena St., Ste. 305
Austin, TX 78723

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NPI:		Provider ID:	
Tax ID number (TIN):		Facility contact name:	
Facility phone:		Facility fax:	
Address:		City, state ZIP code:	
Requested service (for type of service, check all that apply)		**Date/date range of service:**	
ICD-10 code(s):			
CPT® code(s) (include requested units/visits):			
Modifier(s):			
Type of service:	☐ Outpatient ☐ Planned inpatient ☐ Emergent inpatient ☐ Skilled nursing facility ☐ PT ☐ OT ☐ ST ☐ Long-term services and supports/long-term care ☐ Home health ☐ Durable medical equipment ☐ Ambulance ☐ Diagnostic study ☐ Hospice ☐Office visit ☐ Personal care services ☐ Other:_____		
Place of service:	☐ Hospital ☐ Ambulatory surgery center ☐ Office ☐ Home ☐ Independent lab ☐ Nursing facility ☐ Other: _____		
Additional information:			

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Dell Children's Health Plan, please provide the authorization number with your submission in the Additional Information section.

Emergent—Use for **all** non-elective **inpatient** admissions only, when the provider indicates that the admission was urgent, emergent or expedited (for admission on the same day).

Urgent—Use for **outpatient** services only, when provider indicates that the service is urgent, emergent or expedited