P.O. Box 8350
La Verne, CA 91750

NeueHealth

Phone: (888) 293-6383
Fax (Auths): (833) 813-7600
Inpatient Fax: (888) 320-3851

MODIFICATION REQUEST FORM (MRF)

***** IN ORDER TO PROCESS YOUR REQUEST, MRF MUST BE COMPLETED AND LEGIBLE. MRFs MUST BE SENT VIA FAX*****

PROVIDER: Modifications may not be accepted if decision has already been made or authorization is beyond regulatory turn-around time. For routine requests this is 5 days for Medicaid and 14 days for Medicare Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered. Modifications of a referral can be made to update the following: ICD or CPT codes, Number of Units, and Provider/Facility name.

Authorization Request #: _____ Original Authorization Date: _____

Patient Name: _____ M ☐ F ☐ D.O.B. _____ Age: _____
Last First

Name of Facility (if applicable): _____ Member's Health Plan: _____
Member ID : _____

Requesting Provider:	Servicing Provider (Physician, Facility, Vendor):
Provider NPI# _____ Provider TIN#: _____	Provider NPI#: _____ Provider TIN#: _____
Address: _____ Phone: _____ _____ Fax: _____	Address: _____ Phone: _____ _____ Fax: _____
Office Contact: _____	Office Contact: _____
Diagnosis: _____	ICD-10: _____

Originally Requested Authorizations

☐ Inpatient Facility ☐ Outpatient Requests ☐ SNF ☐ Medical Services/Items ☐ Part B Drugs

Date of Services: _____ Admission Date: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	UNITS (REQUIRED)

Requested Modifications

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