Medical Authorization Form

Fax form to: 888.647.6152

Do not use this form for emergent inpatient requests. Missing or incomplete information, including required clinical documentation, may result in delays.

☐ Check if your facility is a participating as an in-network provider for Cigna.

Date of request:_____

Type of Service

☐ Elective/planned inpatient ☐ Home health ☐ Outpatient
☐ Durable Medical Equipment ☐ Other:

Priority

☐ Retrospective ☐ Elective/planned Expedited
☐ Elective/planned Routine

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	

Date(s) of service	From:	To:	
Diagnosis code(s)		Diagnosis	
Procedure code(s)		Procedure	

Provider/facility information

Provider name		Facility name	
Provider TIN		Facility TIN	
Provider NPI		Facility NPI	
Address		Address	

Contact

Name			
Phone		Fax	

Additional information (ex: H&P, labs, vitals, medication record, and imaging):

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**In order to receive payment from any Medicaid program, new federal regulation requires that those providing services to a Medicaid beneficiary must enroll in CHAMPS (Community Health Automated Medicaid Processing System) to receive reimbursement. For more information, go to: https://milogintp.michigan.gov
Contact the Medicaid Provider Helpline 1-800-292-2550

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