1199SEIU Funds
Benefit and Pension

National Benefit Fund • Health Care Employees Pension Fund
Greater New York Benefit Fund • Greater New York Pension Fund
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330 WEST 42ND STREET | NEW YORK, NY 10036-6977 | WWW.1199SEIUBENEFITS.ORG

Care Management Programs
Service/Equipment Request for Authorization

Fax completed form with supporting clinical documentation to (646) 473-7447

Request Submitted By _____ **Request Date** _____ / _____ / _____

1199SEIU MEMBER INFORMATION

Member Name _____ _____
Last Name First Name

Member ID | | | | | | | | | | |

PATIENT INFORMATION (*If not the Member*)

Patient Name _____ _____
Last Name First Name

Date of Birth _____ / _____ / _____

CPT/HCPCS Code(s) & Description

Code _____

Description _____

_____

ICD 10 Code(s) & Description

PRINCIPAL _____

Description _____

_____

SECONDARY _____

Description _____

Member ID									

Patient Name

Last Name

First Name

Complaints pertinent to request:

Pertinent history:

Objective findings:

Is this request relating to post-surgical care? ☐ No ☐ Yes

If yes, Type of Surgery _____ Date ____ / ____ / ____

Prior treatment/medication therapy & outcomes:

Prior diagnostic studies and results:

Treatment plan and expected outcome:

Member ID | | | | | | | | | |

Patient Name

Last Name

First Name

PHYSICIAN INFORMATION *(Ordering/Treating Physician)*

Physician Name

TIN (*Tax ID*)

Physician Specialty

Telephone (____) ____ - _____

Fax (____) ____ - _____

Address

Street Name City State Zip Code

Physician Signature _____ **Date** _____ / _____ / _____

FACILITY/VENDOR INFORMATION *(Facility/Vendor providing the service)*

Facility/Vendor Name

TIN *(Tax ID)*

Telephone (____) ____ - _____

Fax (____) ____ - _____

Address

Street Name City State Zip Code

Vendor Authorized Signature _____

Name _____ **Title** _____

Please print clearly

Contact Person _____ **Title** _____

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD 10 codes must be included.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446.
Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.