1199SEIU Funds
Benefit and Pension

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

# Care Management Programs
# Allergy Request for Authorization
# Benefit Extensions beyond 20 visits/calendar year

**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:

Prior treatment/medication therapy & outcomes:

Prior diagnostic studies and results:

Copy of desensitization records from initial to current: ☐ Yes ☐ No

Treatment plan:

**Member ID** | | | | | | | | | |

**Patient Name**

Last Name _____ First Name _____

## PHYSICIAN INFORMATION

**Physician Name** _____ **Date** _____ / _____ / _____

**Physician Specialty** _____ **Telephone** (____) ____ - _____

**Fax** (____) ____ - _____

**TIN** (*Tax ID*) _____

**Address** _____

Street Name City State Zip Code

## 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.**