Humana
Healthy Horizons™
in South Carolina

Healthy Connections

Authorization Request Form

Please complete form in its entirety and return to:
Email: CorporateMedicaidCIT@humana.com
Fax: **833-441-0950**

☐ Standard	☐ Concurrent	☐ Urgent/Expedited
Urgent/Expedited decisions are rendered within 72 hours of notification. Member's health must be at risk if a decision is not rendered within the standard timeframe. Requires a physician signature. Authorization will be process within the standard timeframe if received without a signature.		
Physician Signature		

Member Information		
Medicaid Number	Humana ID#	DOB
Last Name	First Name	Gender ☐ Male ☐ Female
Phone Number	Language Spoken	
Other Ins. ☐ Yes ☐ No	If yes, please attach a copy of the insurance card or insurance information	

Requesting/Billing Provider Information		
Provider Name	TIN	NPI
Street Address	City, State	Zip
Office Contact	Phone	Fax

Servicing Provider/Facility Information		
Facility Name	TIN	NPI
Street Address	City, State	Zip
Office Contact	Phone	Fax

Authorization Type			
☐ Medical	☐ Behavioral Health	☐ Inpatient	☐ Outpatient
Request Date:	**Start Date:**	**End Date:**	
☐ Vaginal Delivery ☐ C-Section Delivery ☐ Rehabilitation ☐ SNF	☐ Observation ☐ Therapy Services ☐ OP Surgery ☐ Home Health	☐ Premature Labor ☐ NICU ☐ DME ☐ Surgery	☐ Applied Behavioral Analysis ☐ Psychological Testing ☐ SUD ☐ Psychological Testing
☐ Other:			

Diagnosis and Procedure Code			
Primary ICD-10 Code:		Additional ICD-10 Codes:	
CPT Code:	Requested Units:	CPT Code:	Requested Units:
CPT Code:	Requested Units:	CPT Code:	Requested Units:
Additional Information			

Note: In order to process your request timely, you should submit all necessary documentation to support medical necessity with your authorization request.
Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

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