Submit via fax to 1-866-881-9643
or submit via email to Level3@ahhinc.com

Name of requestor	
Date submitted	
Phone #	

MEMBER INFORMATION

Member ID		Cardholder SSN	
Member Name		Member DOB	
Member Address		Benefits Phone #	
Employer Name		Insurance company	
Group Number			

PATIENT INFORMATION

Patient Name		Relationship to Member:	
Patient DOB			

CASE INFORMATION

Case Type	☐ Inpatient ☐ Outpatient
Medical, Surgical, Obstetrics, MH, SA, Surgery, Diagnostic, HHC, DME	
Urgency	☐ Elective ☐ Emergent
	☐ Pre-auth Days authorized

HOSPITAL INFORMATION

Hospital Name	
Address	
City, State Zip	
Phone	

PHYSICIAN INFORMATION

Physician Name	
Address	
City, State Zip	
Phone	
Physician Specialty	

Admission Date / EDC:			
Diagnoses			
Urgency	☐ Elective ☐ Emergent		
Procedure		Procedure Date	

SPECIAL INSTRUCTIONS:	