Outpatient Medical Authorization Request Form

- This form should be used by <u>members</u> requesting an organization determination (authorization requests) for outpatient medical service.

- All sections on this form must be completed. This will help us to decide if we should allow or deny the request.

- This form should not be used for medications.

- Please note if services have already been provided and you are receiving a bill you should NOT complete this form. You would need to contact customer service to submit a member appeal. The phone number is located on the back of your member ID card.

Once the form is complete please mail or fax the request to HAP.

Fax: (313) 664-5916

Mail: Health Alliance Plan (HAP)
Attention 4th floor, Referral Management Team
2850 W. Grand Blvd.
Detroit, MI 48202

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Member ID (11 digits):	Member Name (first and last):
Member Date of Birth (mm/dd/yyyy):	Member Phone Number:

Ordering or Requesting Doctor's Name (first and last): Ordering or Requesting Doctor's Phone Number: Ordering or Requesting Doctors Address:
Please tell us more about the condition that needs treatment (i.e. diagnosis or what problem you are having):

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Where or who would you like to have care provided by? Doctor's name (first and last): Doctors office address: If applicable; Hospital or Facility name: If applicable; Hospital or Facility address:
What is the date of service or when is your appointment?
Other information that you feel is important for HAP to know?