

Medical Authorization Form

Fax form to: 888.647.6152

Do not use this form for emergent inpatient requests. Missing or incomplete information, including required clinical documentation, may result in delays.

Check if your facility is a participating as an in-network provider for Cigna.

Date of request: _____

Type of Service

- Elective/planned inpatient Home health Outpatient
 Durable Medical Equipment Other:

Priority

- [Retrospective](#) Elective/planned Expedited
 Elective/planned Routine

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	

Date(s) of service	From:	To:	
Diagnosis code(s)		Diagnosis	
Procedure code(s)		Procedure	

Provider/facility information

Provider name	Acadian Ambulance Srv of Texas	Facility name	Same
Provider TIN	300688582	Facility TIN	Same
Provider NPI	1750676870	Facility NPI	Same
Address	3720 Corley Ave.	Address	Same
	Beaumont, TX. 77701		

Contact

Name			
Phone	337-521-3560	Fax	337-291-2271

Additional information (ex: H&P, labs, vitals, medication record, and imaging):

**In order to receive payment from any Medicaid program, new federal regulation requires that those providing services to a Medicaid beneficiary must enroll in CHAMPS (Community Health Automated Medicaid Processing System) to receive reimbursement. For more information, go to: <https://milogintp.michigan.gov>
 Contact the Medicaid Provider Helpline 1-800-292-2550

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