Completion of all fields is required.

❏ **URGENT REQUEST**

Per health care reform, urgent means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient's life/health, or the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

> ❏ **FirstCarolina Care Utilization Management and Risk Adjustment Solutions Department**
> *Fax 217-902-9771*
> ❏ **FirstCarolina Care Pharmacy Department**
> *Fax 217-902-9798*

FirstCarolinaCare
INSURANCE COMPANY

REQUEST FORM

MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS

To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay the review process.

_____
Date

_____   _____   _____
Patient Name   Patient Member ID Number   Patient Birthdate

_____   (____) _____   (____) _____
Requesting Physician's Name and NPI   Requesting Physician's Phone Number   Requesting Physician's Fax Number

Diagnosis Code: _____   Diagnosis: _____

Procedure Code: _____   Procedure: _____

❏ Inpatient Procedure (services provided may result in admission)   Anticipated Length of Hospital Stay _____

_____   _____   (____) _____   (____) _____
Facility   Practitioner   Provider Phone Number   Provider Fax Number

Physician Signature _____   Date _____

━━━ Tertiary/Out-of-Network Referrals ━━━

Referred to: _____   _____
    Physician   Facility

Physician Phone Number (_____)   Physician Fax Number (_____)

Service Reason:	**Reason for Request:**
❏ Consult ❏ Consult and Treatment	❏ Not Available in Network ❏ Unable to Schedule in Timely Manner ❏ Member Request
# Visits: _____ Length of Referral: _____	❏ Other *[please specify]* _____

❏ The patient has been encouraged to contact FirstCarolina Care to verify coverage for visiting this provider.

Physician Signature _____   Date _____

━━━ Pharmacy Medical Exception/Rx Preauthorization (Fax to 217-902-9798) ━━━

_____   _____   _____
Drug Requested   Strength   Diagnosis

List [1] Therapy failure on formulary drugs in the same therapeutic/disease class, [2] Why failed, and [3] Medical rationale for request.

1) _____

2) _____

3) _____

Physician Signature _____   Date _____