

NEVADA HEALTH SOLUTIONS PRIOR AUTHORIZATION AND REFERRAL FORM

****All sections of this form must be completed.****
NHS Fax (702) 691-5614

PATIENT INFORMATION				
Primary Insurance? ☐ YES or ☐ NO				
Name of Primary Insurance:				
Patient Name / Member ID#:		Card Holder Name / Member II	D#:	
Patient DOB:		Patient Address / Telephone No.:		
Patient Alternative / Mobile Telephone No.:				
r				
PROVIDER INFORMATION				
Requesting Provider Name / Address / Telephone and Fax No.:			Contact Person / Name:	
		Telephone No. and Extension:		
		Telephone 10. and Extension.		
TEL: • FAX:				
1700		Fax No.:		
NPI: Tax ID:		* Scheduling Issues do not meet the definition of Urgent		
Primary Care Provider Name / Address / Telephone and Fax				gent request is the imminent and
No.:		serious threat to the health of th		
			limited to: severe pain, potentia	
			bodily function and a delay in d jeopardize the life or health of t	
TEL: • FAX:		jeopardize the fire of health of t	ne patient.	
AUTHORIZATION REQUEST			PENDING REF #:	NO FAX PAGES:
Date of Request:	☐ Inpatient	Procedure Date:	No. of Treatments Requested:	Is Service Requested by
	☐ Observation			Patient:
	☐ Outpatient			☐ Yes or ☐ No
Diagnosis (include ICD Code)			Procedure/Treatment Request (i	nclude CPT Code)
Servicing Provider Name / Address / Telephone No.:			Place of Service / Name of Faci	lity / Addrass / Talanhana No :
Servicing Frovider Name / Address / Telephone No			Trace of Service / Ivanic of Faci	nty / Address / Telephone 140
☐ SAME AS REQUESTING PROVIDER			NPI:	Tax ID:
PLEASE attach the latest available Medical Records and Progress Notes.				
*All procedures/treatments requested require clinical information and should be submitted with this form to prevent processing delays.				
Pertinent Attachments = Information to support the proposed diagnosis, treatment / procedure, i.e. current clinical findings				
(Progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted.				
On adverse determinations a reconsideration / expedited appeal may be requested.				

*Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is proprietary & confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

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