AUTHORIZATION REQUEST FORM

(PROVIDER)

GENERAL INFORMATION ABOUT AN AUTHORIZATION REQUEST

Some Zing Health covered medical care require an approved authorization for services to be covered and reimbursed under the member's Zing Health benefit coverage. Please refer to the Authorization List in your provider manual to see if the service you are requesting requires prior authorization. You may also contact Zing's Customer Service to speak with a representative for assistance.

1-866-946-4458 (TTY: 711)
8 a.m. to 8 p.m. 7 days a week (from October 1 - March 31)
8 a.m. to 8 p.m. Monday through Friday (April 1 - September 30)

Your office will most likely complete the documentation for the member since you have the clinical information that we will need to review the request. However, the member may also complete the request and we will reach out to your office to obtain the needed information. All fields on the Authorization Request From are required to be filled out. This will ensure a thorough review of the request.

You are not required to use the Authorization Request Form to request authorization for a member, however, we find it helpful in collecting all the information that we will need from you and avoid delays in processing.
The authorization number is a number that Zing Health will generate for your reference once we receive and begin processing the request.

For non-urgent requests, please allow up to 14 calendar days for a response. We will notify you verbally and/or in writing of our decision.

SUBMITTING THE COMPLETED REQUEST

Please send the completed request to the contact below:

Authorization Requests for Medical Care
Zing Health
Attn: Prior Authorization
225 W. Washington Street Suite 450
Chicago, IL 60606
Fax: 1-844-946-4458
Email: prior_auth@myzinghealth.com

Zing HEALTH™

AUTHORIZATION REQUEST FORM

***FAX NUMBER TO SEND DECISION TO: _____ (Add Fax Number)**

AUTHORIZATION REQUEST DATE: _____

REQUESTING PROVIDER INFORMATION

Name: _____

Address: _____

City, Zip Code: _____

Phone: _____

Fax: _____

Contact Person: _____

NPI Add: _____

PATIENT INFORMATION

Name: _____

Member ID#: _____

Date of Birth: _____

SERVICE REQUESTED/PLAN OF TREATMENT FOR REQUEST

Date of Service (DOS): _____

Service(s) Requested: _____

Diagnosis (ICD - 10 Code(s): _____

CPT Code(s) Quantity for each code-add. For DME Supplies Please label each code as purchase or rental. If code is for rental note length of rental: *(Example 99213 x 4)* _____

_____

_____

Servicing Provider/Facility: _____

NPI: _____

Phone: _____

Fax: _____

Address: _____

City, Zip Code: _____

Other: _____