AUTHORIZATION FORM

AUTHORIZATION REQUEST

Authorization #

Date of Request

PROVIDER INFORMATION

Name

Address

City, Zip Code

Phone

Fax

Contact Person

PATIENT INFORMATION

Name

Member ID#

DOB

SERVICE REQUESTED/PLAN OF TREATMENT FOR

REQUEST

Date of Service (DOS)

Service Requested

Diagnosis (ICD - 10 Code(s)

CPT Code(s)

Provider/Facility

Phone No.

Address

City, Zip Code

Procedure

Other

CLINICAL INFORMATION

Service Provider Instructions:
- Verify member eligibility and benefits prior to rendering service
- Submit written authorization request for services in italics in the Evidence of Coverage Medical Benefit Chart to:

Zing Health
Attn: Prior Authorization
303 W. Madison St., Ste. 800, Chicago, IL 60606
Email: prior_auth@myzinghealth.com
Fax No.: 844-946-4458”