COSMETIC AUTHORIZATION FORM

Date: _____ Auth #: _____

Fax to: **502-213-8998** PHP R.N. Initials: _____

Attn: **PHP Home Health**

REQUEST CAN BE SENT VIA SECURE EMAIL TO: **UMCosmetics@passporthealthplan.com**

Please complete this form and attach to all cosmetic requests.

☐ Check mark for date of service change – complete asterisks ** only

MEMBER INFORMATION

MEMBER'S NAME ** _____

PASSPORT ID ** _____ MEMBER'S DOB _____

PROVIDER INFORMATION

ORDERING MD _____

PROVIDER / MD CONTACT ** _____ CONTACT PHONE # ** _____

PROVIDER MD FAX ** _____

☐ INPATIENT ☐ OUTPATIENT ☐ 23 HOUR OBSERVATION

FACILITY _____

CLINICAL INFORMATION

DATE OF SERVICE ** _____

DIAGNOSIS _____

CPT CODE WITH DESCRIPTION _____

PREVIOUS ASSOCIATED SURGERIES _____

CLINICAL SUMMARY: _____

If photos are required, request must be mailed to:

Passport Health Plan – Attention Cosmetics
5100 Commerce Crossing
Louisville, Ky. 40229