Affinity Health Plan

Request for Out of Network Authorization

Please Fax to: (718) 794-7822 (Revised 11/1/2016)

Member Name _____

Date Of Birth ___/_____/_____

Affinity ID # _____

Date of Request ___/____/_____

Please circle your current plan:

Medicaid CHP AffinityAccess

Medicare Essential Plan

Enriched Health

Name of Physician _____

TIN # _____

NPI # _____

Address _____

Phone# (____) _____ - _____

Fax # (____) _____ - _____

Describe Care/Service Request:

	Date of Service	Place of Service	Diagnosis code	Diagnosis description	Procedure code	Procedure description
Elective						
Ambulatory Surgery						
DME						
Home Care						
Transplant						
Non-Emergent Ambulance						
Other						

Please select from the following reasons why this Member was referred out of the Affinity Health Plan Network:

- No specialist/sub specialist within geographic area: What is the specialty? _____
- Medical Necessity: fax supporting documentation _____
- Follow up from Hospital admission or Emergency room visit _____
- Continuity of Care: fax supporting documentation _____

(*If a new Member has an existing relationship with a provider who does not participate in the Affinity network or an existing Member's provider has left the Affinity network, Affinity permits the Member to continue an ongoing course of treatment with the non-participating provider for a transitional period under certain circumstances*).

- Other: _____
- Referred by PCP/Specialist? _____
- Member self-referral Yes / No

Plan of Care

If approved, authorization for service does not constitute a guarantee of payment by Affinity Health Plan. Payment for the service(s)