Horizon NJ Health

Date of Request: _____

In place of this form you can submit Authorization Requests online securely via NaviNet. If you are not registered, please visit NaviNet.net and click *Sign Up* or call NaviNet Customer Care at 1-888-482-8057.

Cardiac/Pulmonary/Cognitive/Nutritional Therapy Authorization Request Form Requirements: *Clinical information and supportive documentation including office visit notes and recent diagnostic test results must be submitted to support request for approval.* ***Notification required for any date of service change.***

Fax completed form to: Horizon NJ Health **1-609-583-3014**

General Information

Member Name: _____ **Member ID #:** _____ **DOB:** _____

Provider Contact Name: _____ **Phone #:** _____ **Fax #:** _____

List Any Additional Insurance: _____

Policy Name/Number: _____

Medical Information Needed

Date/Date Range of Service: _____

Days/Units Requested: _____

Primary Diagnosis: _____ **Other Chronic Diagnosis:** _____

ICD-10 Codes: _____

Procedures(s) Requested: _____

CPT Codes Requested: _____

Requesting Provider: _____ **ID # & NPI #:** _____ **TIN #:** _____

Servicing Facility: _____ **ID # & NPI #:** _____ **TIN #:** _____

Location of Service: ☐ **Home** ☐ **Hospital** ☐ **Other** _____

Additional Required Information

☐ **Cardiac Therapy**

- **Type of cardiac event: (MI, CABG, angioplasty, heart valve, transplant surgery)** _____
- **Date of cardiac event:** _____ **Name of treating physician:** _____

☐ **Pulmonary Therapy**

- **Reason for therapy (LVRS, COPD, Cystic Fibrosis, interstitial pneumonitis, thoracic deformities, pre-/post-lung transplant)** _____ **Name of treating pulmonologist:** _____

Cognitive Therapy

- **Reason for therapy: (head injury, other neurological disorders)** _____

☐ **Nutritional Therapy**

- **Name of "medical food" or "low protein modified food product":**

_____