RHYTHMM.AI

PRE-AUTHORIZATION REQUEST

Submit completed forms and clinical information outlined below by uploading to our secure server within your Rhythmm facility portal or send via fax to 918-777-3415. If uploading, please upload only one file per patient (PDF only) and ensure that uploaded information includes basic patient identifying information.

“A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.” - Department of Labor

I certify that this request meets the above definition for urgent processing according to the Department of Labor.

Patient Information

Last Name	**First Name**	**Date of Birth**
SSN	**Subscriber SSN**	**Gender**
Street Address	**Street Address 2**	**City**
State	**Zip Code**	**Relationship**
Group Number/Policy ID	**Group Name/Policy Name**	**Member Number**

Referring Provider Information

NPI Number	**Tax Identification Number**	**First Name**	**Last Name**
Facility Name	**Email Address**	**Phone Number**	**Fax Number**

Requester Information

NPI Number | Tax Identification Number | First Name | Last Name

Facility Name | Email Address | Phone Number | Fax Number

Services Request

Inpatient ☐ Outpatient ☐ Office/Clinic ☐ Free Standing Facility ☐ Hospital ☐ Scheduled ☐ Unscheduled ☐

Requested Length of Stay (Days) | Start Date | End Date

23 HR Observation ☐ Chronic Care ☐ DME ☐ Injectable/Infusion ☐ Genetic Test/Complex Labs ☐

In Office Service or Procedure ☐ Imaging & Radiology ☐ Out of Network Waiver ☐

Preventative Procedure or Service ☐ Surgery ☐ Chiropractic Description ☐

or Service Requested (Please Provide Specifics)

Is this an established diagnosis for the Patient? ☐

Is there prior history of services provided that relate to this Prior Authorization? ☐

If you checked yes to either of these questions please provide details below.

ICD Code(s)	CPT Code(s)

If appropriate, please provide the following clinical information in the Upload or attach with the e-fax.

- **Most recent History & Physical**
- **Most recent office visit note(s) documenting symptoms and conservative therapy as applicable**
- **Related imaging reports, i.e, X-ray, MRI, CT**
- **Related laboratory reports**
- **Related Operative Reports**
- **Written Prescription for DME, Therapies, etc. as applicable**
- **Any other pertinent clinical information that substantiates medical necessity for the requested service(s)**

Submit completed forms and clinical information outlined below by upload to our secure server within your Rhythmm facility portal or send via fax to 918-777-3415. If uploading, please upload only one file per patient (PDF only) and ensure that uploaded information includes basic patient identifying information.