



Fax requests to: 888-633-4052

### Medical Service Request Form

Please complete this authorization form for South Country Health Alliance members. **Submission of this form does not guarantee approval. Incomplete requests cannot be processed and will be returned to requestor for completion.**

**\*\*Please include supporting documentation with the submission of this form (history of illness, face to face, lab/diagnostic results, etc.).**

Auth Specific Contact				
Contact Name	Contact Phone Number		Contact Fax Number	
Ordering Provider				
Provider Name	Phone Number	Fax Number	Ordering Provider NPI	Ordering Provider TIN
Provider/Facility Name		Provider/Facility Address		
Servicing Provider/Facility				
Servicing Facility <input type="checkbox"/> Same as above	Phone Number	Fax Number	Servicing Provider/Facility NPI	Servicing Pvd/Facility TIN
Servicing Facility Address				
Member Information				
Member Name	Member ID	DOB	Member Address	
Medical Service Requested:				
Surgery <input type="checkbox"/> DME <input type="checkbox"/> Home Health Care <input type="checkbox"/> Medical Dental <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Diagnostics <input type="checkbox"/> Experimental <input type="checkbox"/> Transplant <input type="checkbox"/>				
Benefit Exception <input type="checkbox"/> Wound Care <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Cosmetic <input type="checkbox"/> Other (Please Specify) <input type="checkbox"/> _____				
Place of Service:				
Doctor's Office <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Home <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Other <input type="checkbox"/>				
Procedure Code	Modifier	Diagnosis Code	Description	
QTY/Units	Amount/Cost	Start Date	End Date	
Procedure Code	Modifier	Diagnosis Code	Description	
QTY/Units	Amount/Cost	Start Date	End Date	
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***Please contact the Provider Contact Center at 888-633-4055 for questions related to claims.  
Please contact Utilization Management at 888-633-4051 for questions related to Service Request forms.***

*If this request is in response to a claim denial, please resubmit the claim and include the South Country Authorization number.*

**\*\*If your facility has never billed South Country Health Alliance, you will need to submit additional documents with this form. These documents can be found on our website at <https://mnscha.org>.**

**\*\*Approval and denial letters will be faxed to the number provided in the Return Fax Number.**

*This faxed information is intended for the individual or entity to which it is addressed and contains information that is confidential. Furthermore, this information may be protected by Federal law relating to confidentiality (42 CFR Part 2) prohibiting any further disclosure. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any review, dissemination, distribution, or copying of this communication is strictly prohibited. If you have reviewed the communication in error, please notify us immediately by telephone and return the original message to us by the above address via mail. Thank you.*