



OUTPATIENT NOTIFICATION FORM

FAX TO: 801-270-3010

Please provide ALL of the following information to prevent delays in processing your request.

Member name, Patient name, Physician name, Facility name, ICD-10, Name of procedure, etc.

Contact name, Phone number, Today's date, Fax number/email

For EMI Health's use only

Authorization number, Date returned

This authorization is based on the information provided to us and the patient's eligibility and plan benefits as of the date of this notice. This authorization is valid for five days from the scheduled date of service, based on the following conditions: 1) there are no changes to any of the reported information listed above; 2) premium payments are current for the date of service; 3) the patient is still covered by the plan at the time of service; 4) the panel status of the physician and facility have not changed; and 5) there are no changes to the plan benefits that cover the patient on the dates of service.

IMPORTANT NOTICE: This fax, including any attachments, contains information that may be proprietary, confidential, or privileged, and is intended solely for the entity or individual to whom it is addressed.