meridian

300 S. Riverside Plaza, Suite 500
Chicago, IL 60606

866-606-3700 (TTY 711)
ILmeridian.com

FIRST AND LAST NAME _____
ADDRESS 1 _____
ADDRESS 2 _____
CITY, STATE, ZIP CODE _____

DATE _____

Dear Meridian Provider,

Provider/Group:	Member Name:
Provider Fax:	Member ID:

We are unable to process your authorization request due to missing or incomplete information. Please fax a revised authorization request for consideration that includes information related to the boxes marked with an "X."

Inpatient Fax: **833-544-1827** Outpatient Fax**: 833-544-1828**

Refer to boxes marked with an "X"

☐ Name of Provider is missing or illegible

☐ Provider is not an approved Meridian network provider

☐ Provider's signature is not on form

☐ Eligibility cannot be verified for the member

☐ Member's coverage terminated on: _____

☐ Initial date of service is missing

☐ Requested start date is missing

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☐ Requested CPT code is missing

☐ Diagnosis is missing

☐ Risk Assessment is not completed

☐ Incorrect form used

☐ Incomplete treatment plan information

☐ Member has active authorization for similar service. Member must contact Meridian.

☐ Duplicate Request. Original authorization number: _____

☐ We cannot backdate your request to start on (date): _____

☐ Please submit a completed OTR within the current month

☐ Other: _____

If you have any questions, please call Meridian Customer Service at **866-606-3700,** TTY **711.**

Thank you,

Meridian BH Utilization Manager

_____

As a reminder, authorization is based upon medical information provided. This authorization is not a guarantee of benefits or payment. Meridian will not pay claims for members who are not eligible for benefits at the time of service. It is the member's responsibility to notify the provider of any changes in their benefit plan. Payment of benefits is subject to any subsequent review of medical information or records, the member's eligibility on the date the service is rendered, and any other contractual provisions of the plan.