[Insert Provider Name, Address, Phone Number]

**NOTICE OF AUTHORIZATION OF SERVICES -**

**[SECOND OPINION][THIRD OPINION]**

Date: [Date]

[Name of Member]

[Address]

 Important Plan Information

|  |  |
| --- | --- |
| DOB: | [Date of birth] |
| Member ID: | [Member ID] |
| Health plan: | SCAN |
| Requesting practitioner: | [Provider full name] |
| Requested provider: | [Requested provider full name] |
| Authorization/precertification #: | [Authorization number] |

Dear [Name of member],

We want to let you know that the request for a [second opinion][third opinion] office visit has
been approved.

Please be aware that this [second opinion][third opinion] is for an ***office visit only***:

* This is not an authorization to transfer your care to the doctor or facility that gives the [second opinion][third opinion].
* This is not an authorization for blood tests, X-rays, scans or any other testing.

After this office visit, you must return to your primary care doctor for care. Together, you and your doctor will review the results of the visit and discuss any recommendations. If you need other services, your primary care doctor will manage your care.

**The following service(s) has been approved:**

|  |  |  |
| --- | --- | --- |
| **Service Code:** | **Service Code Description:** | **Unit(s):** |
| SERVICE\_CODE1 | SERVICE\_DESC\_CODE1 | UNITS\_AUTHORIZED\_1 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE2 | SERVICE\_DESC\_CODE2 | UNITS\_AUTHORIZED\_2 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE3 | SERVICE\_DESC\_CODE3 | UNITS\_AUTHORIZED\_3 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE4 | SERVICE\_DESC\_CODE4 | UNITS\_AUTHORIZED\_4 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE5 | SERVICE\_DESC\_CODE5 | UNITS\_AUTHORIZED\_5 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE6 | SERVICE\_DESC\_CODE6 | UNITS\_AUTHORIZED\_6 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE7 | SERVICE\_DESC\_CODE7 | UNITS\_AUTHORIZED\_7 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE8 | SERVICE\_DESC\_CODE8 | UNITS\_AUTHORIZED\_8 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE9 | SERVICE\_DESC\_CODE9 | UNITS\_AUTHORIZED\_9 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE10 | SERVICE\_DESC\_CODE10 | UNITS\_AUTHORIZED\_10 |

**Authorization valid from:** [Begin date] **to** [End date]

This service is approved based on medical necessity and your eligibility and plan benefits. Your provider/practitioner will confirm your eligibility at the time you actually receive the service.

**Please note that you are responsible for any cost share, copayment or any applicable member responsibility.**

In order to use this authorization, you need to be a member of SCAN during the time of service [Begin date] to [End date]. You must use the authorization within 60 days of it being issued, which is from [Begin date] to [End date]. SCAN will need to review future authorizations to decide if the service(s) is medically necessary.

If you have any questions, SCAN Member Services is here to help. Please contact our Member Services number at 1-800-559-3500 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30 hours are 8 a.m. to 8 p.m., Monday through Friday.

Messages received on holidays and outside of our business hours will be returned within one business day.

[Provider department information]

CC: [Authorized provider full name]

 [Ordering physician full name]

**Note requested provider/practitioner:** Confirm member’s eligibility prior to providing care/service. The care/service is approved only if the member is eligible at the time of service.