[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 Health Plan |
| 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 note 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 and make any further authorization requests through either your medical group or SCAN, your health plan.

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

|  |  |  |
| --- | --- | --- |
| **Service Code:** | **Service Code Description:** | **Unit(s):** |
| SERVICE\_CODE 1 | SERVICE\_DESC\_CODE1 | UNITS\_AUTHORIZED\_1 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE 2 | SERVICE\_DESC\_CODE2 | UNITS\_AUTHORIZED\_2 |

|  |  |  |
| --- | --- | --- |
| SERVICE\_CODE 3 | 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. In order to use this authorization, you need to be a member of SCAN during the time of service. Your provider/practitioner will confirm your SCAN membership at the time you actually receive the service.

You must use this authorization within 60 days, which is from [Begin date] to[End date].

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

If you have any questions, please call SCAN Member Services at 1-800-559-3500 (TTY users should call 711). You can also ask Member Services for a free copy of the information used to make this decision. This may include guidelines and other documents. Member Service 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.