Surgical Treatment of Obstructive Sleep Apnea

1. Initial Contact Information
   - Office Contact Name

2. Provide direct phone number and extension to individual requesting authorization

3. Office Fax Number

4. Is this an out of network/out of plan request?
   - (None)

5. If out of network/out of plan complete this section
   - Who is requesting out of network/out of plan request?
     - (None)
   - What participating provider(s) has the member already seen?
   - What were the participating provider's recommendations?

6. Is the requested service available within the member's network/plan?
   - (None)

7. Please provide the rationale and any pertinent documents to support the request for out of network/out of plan services.

8. Surgical Treatment of Obstructive Sleep Apnea
   - Provide the surgical procedure being requested