



BHRS Authorization Correction Form

Member Name: _____ Member DOB: _____

Member ID#: _____

Provider Name: _____

Provider Address: _____

Contact Person: _____

Phone Number: _____

Plan of Care Dates: _____

Please enter below the Prescription Hours Below

Service	Hours Prescribed
TSS	
MT	
BSC	
Site Based	
CRR	
Other	

Please provide a brief description of what is incorrect with the authorization.

Please fax all authorization correction requests to 724-744-6557.