

**SUMMIT POINTE PROVIDER GAP IN AUTHORIZATION FORM**

**Provider Information**

**Provider Name:** \_\_\_\_\_

**Program/Home Name:** \_\_\_\_\_ **Contact Name:** \_\_\_\_\_

**Contact Email:** \_\_\_\_\_ **Contact #:** \_\_\_\_\_

**Gap in Authorization information**

**Customer Name:** \_\_\_\_\_ **Customer DOB:** \_\_\_\_\_ **Customer ID #** \_\_\_\_\_

**Billing Code [CPT + Modifier]:** \_\_\_\_\_

**Dates Of Service:**

\_\_\_\_\_

**Total Units Requested per billing code:** \_\_\_\_\_

**Provide documented efforts to obtain authorizations** (attach emails/phone logs etc):

\_\_\_\_\_  
**External Provider Signature**

\_\_\_\_\_  
**Date**

**Send completed form to:**

Summit Pointe - Utilization Management Department  
Email: [#LCM-External@summitpointe.org](mailto:#LCM-External@summitpointe.org)

Attached any additional documentation if applicable.

Must be submitted with 120 days of gap.

Failure to adequately complete this form or provide necessary documentation could result in an automatic denial