



Authorization Revision Request Form for Providers

Provider Name

Date of Revision Request

Member Name

iCircle Member Number

Care Manager Name

Change Requested Category	Authorization Number	Revision Needed
Service Dates		
NPI Number		
CPT/HCPC Code		
Units		
Diagnosis		
Other		

Brief Description for Change Requested

Return To:

authrevisionreq@icirclecny.org