AMERICAN HEALTH ADVANTAGE OF TENNESSEE

Auth. Submission Fax: 844-869-0884

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage

AUTHORIZATION REQUEST

Member Name ______________________ DOB __________ Member ID ______________________________

Nursing Facility ____

Requesting Provider / Type ____________________________________ NPI: ___________________________

Phone #: _________________________________ Fax #: ____

Primary Diagnosis ____

Diagnoses (ICD-10 Codes) Related to Auth Request ____

Servicing Provider/Facility: _____________________________________ Tax ID #: __________________________

Servicing Provider Phone#: __________________________ Servicing Provider Fax#: ___________________________

Include all Clinical Documentation with request. NOTE: A delay in submitting all relevant and necessary clinical required to make a medical necessity decision may result in a delay in receiving an authorization determination.

SNF (After Discharge) Inpatient Admit Behavioral Health Outpatient Services SIP (Skill in Place)

Start Date for above service checked ____________ (this field must be completed)

Home Health DME: Rental or Purchase (indicate one). Office Visit: New Patient Follow/up

Diagnostic Testing or Procedure (List Type and CPT code) ____

Provider/Facility: __________________________________Scheduled Date for Services (if Scheduled) ______________

CPT Codes & Quantities:____

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THERAPY REQUEST

REQUEST FOR PART B THERAPY SERVICES (<u>attach care plan, initial evaluation, and most recent therapy notes</u>)

Request for PT OT ST Other ______________________________________

Start Date of Services: __________ Date of Initial Evaluation: ______________ Date of Last Exam: ________________

Request is for Initial Visits Additional visits

# of PT Therapy: ______________ __________ Times per Week For ____________ weeks

# of OT Therapy: ______________ __________ Times per Week For ____________ weeks

# of ST Therapy: ______________ __________ Times per Week For ____________ weeks

List of CPT Codes ____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Standard Authorization: Authorization Requests (properly completed and includes supporting medical record documentation, when required) from a PCP or Plan NP are completed within 14 days per the CMS guidelines. Our goal is 5-7 days

Expedited Authorization (Must Read and SIGN): By signing below I certify that waiting for a decision under the standard time frame could place the Member's life, or health in serious jeopardy.

SIGNATURE: __________________________________Date Completed:_________________________

Name of Person Completing this form: ______________________________________

Notification will be faxed upon determination. Please complete the following for notification of decision.

Who is Receiving Authorization Notification FAX: __________________________________

Contact#: ___________________________________ Authorization Notification FAX:_____________________

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

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