

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)

SNF (After Discharge) Inpatient Admit Behavioral Health Outpatient Services SIP (Skill in Place) Start Date _____
 Home Health DME: Rental or Purchase (circle one) Office Visit: New Patient Follow/up
 Diagnostic Testing or Procedure (List Type and CPT code) _____

List Provider/Facility: _____

Scheduled Date for Services (if Scheduled) _____

CPT Codes & Quantities: _____

THERAPY REQUEST

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

Request for PT OT ST Other _____

Therapy Treatment Plan Additional Therapy Days In Progress

Start date of Services: _____ Date of Initial Evaluation: _____ Date of Last Exam _____

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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