

# REQUEST FOR AUTHORIZATION OF SERVICES

**PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER AND FOR CERTAIN SERVICES BY PARTICIPATING PROVIDERS. 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/TIN: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

Diagnoses (ICD-10 Codes) Related to Auth. Request \_\_\_\_\_

Servicing Provider/Facility: \_\_\_\_\_ NPI/TIN: \_\_\_\_\_

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.**

Inpatient Admit     Observation     Behavioral Health Admit     SNF (post hospital discharge)     SIP (Skill in Place)

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

DME     New Patient - Non-participating Physician Office Visit     Follow-up - Non-participating Physician Office Visit

Procedure Code(s)/Quantities: \_\_\_\_\_ Scheduled Date for Services \_\_\_\_\_

Diagnostic Testing or Procedure (List Test or Procedure) \_\_\_\_\_

Procedure Code(s) \_\_\_\_\_ Scheduled Date for Services \_\_\_\_\_

**THERAPY / HHC**

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

Request is for     Initial Visits     Additional visits

	# Visits Requested	Frequency	Procedure Code(s)	SOC	Evaluation
PT	_____	W_____	_____	_____	_____
OT	_____	W_____	_____	_____	_____
ST	_____	W_____	_____	_____	_____
HHA	_____	W_____	_____	_____	N/A _____

**TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION**

**Standard Authorization:** Authorization Requests (properly completed and including supporting medical record documentation) 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 (please print name): \_\_\_\_\_

**Notification will be faxed upon determination; please complete the following for notification of the decision.**

Who is Receiving Authorization Notification Fax (please print name): \_\_\_\_\_

Contact phone number: \_\_\_\_\_ Authorization Notification Fax number: \_\_\_\_\_

**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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