IOWA HEALTH ADVANTAGE

# REQUEST FOR AUTHORIZATION OF SERVICES

**FAX REQUEST TO: (866) 516-3068**

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 number: (_____) _____ Fax number: (_____) _____

Primary diagnosis: _____

Diagnoses (ICD-10 codes) related to auth. request: _____

Servicing provider / type: _____ NPI / TIN: _____

Servicing provider phone number: (_____) _____ Servicing provider fax number: (_____) _____

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 (mandatory)** : ___ / ___ / ___

☐ 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 / Home Health Care

**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

| | Number of visits requested | Frequency | Procedure code(s) | SOC | Evaluation |
|---|---|---|---|---|---|
| Physical therapy | | W | | | |
| Occupational therapy | | W | | | |
| Speech therapy | | W | | | |
| Home health aide | | 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): _____

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

Who is receiving authorization notification fax (please print): _____

Contact phone number: (_____) _____ Authorization notification fax number: (_____) _____