IOWA HEALTH ADVANTAGE

REQUEST FOR AUTHORIZATION OF SERVICES

FAX REQUEST TO: (866) 381-1194

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 ☐ Hospital Observation ☐ Behavioral health admit ☐ SNF (post hospital discharge)

☐ Outpatient Services ☐ Diagnostic Testing ☐ Therapy ☐ Home Health ☐ Other

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) / # of units (include all dates of service):

_____

_____

_____

_____

To be completed by person requesting authorization

___ **Standard authorization**: authorization requests (properly completed and including supporting medical record documentation) are completed within 7 days per the CMS guidelines. Our goal is 2 – 3 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: (____) _____

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. This facsimile message is privileged and confidential. It is transmitted for the exclusive use of the addressee. This communication may not be copied or disseminated except as directed by the addressee. If you have received this communication in error, please notify us immediately.