

Auth. Submission Fax: 800-513-0740

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		N	IPI/TIN:	
	Phone #:		Fax #:		
	Primary Diagnosis				
	Diagnoses (ICD-10 Codes) Related to Auth. Request				
	Servicing Provider/Facility:			NPI/TIN:	
	Servicing Provider Phone#:	Servicing Provider Fax	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 ☐ Observa	ation 🗌 Behavioral l	Health Admit ☐ SNF (post he	ospital discharge)	☐ SIP (Skill in Place)
	Start Date for service ch	necked above	(this field r	must be completed)	
	☐ DME ☐ New Patie	ent - Non-participating P	hysician Office Visit	w-up - Non-participat	ing 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				
	# Visits Requested	Frequency	Procedure Code(s)	soc	Evaluation
		W			
	ST	W			
	нна	W			N/A
то в	LECOMPLETED BY PERSON	REQUESTING AUT	THORIZATION		
days pe	ndard Authorization: Authorization R		ted and including supporting medic	al record documentation	on)are completed within 14
Fyn	er the CMS guidelines. Our goal is 5-7	•	w I certify that waiting for a decision	under the standard tin	ne frame could place the
	er the CMS guidelines. Our goal is 5-7 edited Authorization (Must Read an er's life, or health in serious jeopardy.	•	v I certify that waiting for a decision	under the standard tin	ne frame could place the
Membe	edited Authorization (Must Read an	d Sign): By signing below			
Membe	edited Authorization (Must Read an er's life, or health in serious jeopardy.	d Sign): By signing below	Date Com	pleted:	
Member SIGNA	nedited Authorization (Must Read an er's life, or health in serious jeopardy. TURE: of Person Completing this Form (pleas	d Sign): By signing below	Date Com	pleted:	
Member SIGNA Name	nedited Authorization (Must Read an er's life, or health in serious jeopardy. TURE: of Person Completing this Form (pleas	d Sign): By signing below see print name):ed upon determination;	Date Complete the following for	pleted: or notification of the	decision.
Member SIGNA Name of Who is	redited Authorization (Must Read an er's life, or health in serious jeopardy. TURE: of Person Completing this Form (pleas Notification will be fax Receiving Authorization Notification F	d Sign): By signing below see print name):ed upon determination; sax (please print name): _	Date Complete the following for	pleted: or notification of the of	decision.

authorized or outside approval dates will be subject to denial of payment.

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