PPHP
PROVIDER PARTNERS HEALTH PLANS

Auth. Submission Fax: (844) 593-6221

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 Member Handbook/Certificate of Coverage

MEMBER DATA

Member Name ______ Date of Birth ______ Member ID ______

Nursing Facility ______

Ordering Provider ______ Phone #: ______ Fax #: ______

Primary Diagnosis (ICD-10 Code # & Description) ______

Requesting Facility Name:

Requesting Facility Address:

Requesting Facility Phone#: ______ Requesting Facility Fax #: ______

Requesting Facility NPI#: ______

AUTHORIZATION REQUEST

SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)

☐ SNF Part A DME ☐ Inpatient ☐ Continuation/Additional Days

☐ Specialist Visit Specialist Type: ______ Name: ______ Office Phone: ______

Diagnostic Testing or Procedure (List Type, CPT code w/description) ______

List Requesting Provider Name: ______

Requesting Provider Address: ______

Start Date/End Date: ______ Service: ______

Requesting Provider NPI#:

THERAPY REQUEST

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

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 Days Requested: ______ ______ Times per week For ______ weeks

# of OT Therapy Days Requested: ______ ______ Times per week For ______ weeks

# of ST Therapy Days Requested: ______ ______ Times per week For ______ weeks

List of CPT Codes: ______

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** Most services if requested by or with a written order from a PCP or Plan NP are "auto-authorized" within 8 hours or less. CMS allows 14 days for standard authorizations. 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: ______

Name of Person Completing this form: ______ Date Completed: ______

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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