Auth. Submission Fax: (844) 593-6221

Provider Partners Health Plans

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/Facility - Provide name, address, phone #, fax #, and NPI #: _____

_____

_____

_____

AUTHORIZATION REQUEST

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

☐ SNF Part A ☐ DME ☐ Inpatient ☐ Home Health Care *Indicate Therapy below

☐ Inpatient Psych ☐ Continued Stay Review ☐ Part B Drug ☐ Specialist Visit

Specialist Type: _____ Name: _____ Office Phone: _____

Primary Diagnosis (ICD-10 Code # & Description): _____

_____

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

_____

Part B Drugs (List CPT code, Dosage, Frequency, Quantity): _____

List Rendering Provider: _____

Rendering Provider Address: _____

Start Date: _____ End Date: _____ Service: _____

Rendering 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 ☐ Skilled Nursing Visits ☐ Other:

☐ Additional Therapy Days ☐ Therapy Treatment Plan ☐ 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

# of Skilled Nursing Visits Requested: _____ Times per week For ____ weeks

List of CPT Codes: _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** CMS allows 7 days for standard authorizations. Our goal is 3-5 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 thoseauthorized or outside approval dates will be subject to denial of payment.