Medicare Advantage Plans

Prior Authorization Form

Before submitting this form, verify eligibility, benefits, and prior authorization requirements.

Date of Request: _____

Fax: 888-683-1684
Phone: 866 255-4795

Requestor's Contact Name:	**Requestor's Contact #:**
***Member Name:**	***Member DOB:**
***Member ID:**	***Member Phone #:**
***Member Address:**	

Service is: *(Please Select)*

Standard processing timelines will apply for all non-urgent requests

☐ New Request

☐ Emergent / Urgent — Use only if the health of the member may be seriously jeopardized if this request is not reviewed urgently. Scheduling issues do not meet the definition of an urgent request.

☐ Existing Request Please enter authorization #: _____

Additional Information Submitted: ☐ Clinical information ☐ Discharge information ☐ Reconsideration Request

Other: _____

Service Type Requested: *(Please review plan benefits prior to request)* ***For existing authorizations, do NOT complete the fields below**

Outpatient Medical

- ☐ Ambulatory Surgery
- ☐ Ambulatory Surgery with Obs
- ☐ Dental
- ☐ Dialysis
- ☐ DME & Supplies
- ☐ Home Care
- ☐ Imaging/Radiology
- ☐ Lab/Diagnostic Testing
- ☐ Drug Administration
- ☐ Observation Stay
- ☐ Office/Clinic Visits
- ☐ Other Outpatient Medical Service
- ☐ Rehabilitative/ Therapy Outpatient
- ☐ Other: _____

Outpatient Behavioral

- ☐ Applied Behavioral Analysis
- ☐ ETC
- ☐ Intensive Outpatient Program (IOP)
- ☐ Outpatient Treatment
- ☐ Partial Hospitalization Program (PHP)
- ☐ Psychological Testing
- ☐ Transcranial Magnetic Stimulation
- ☐ Other: _____

Inpatient Medical

- ☐ Skilled Nursing
- ☐ Inpatient Surgery/Procedure
- ☐ Other: _____

- ☐ **Request is associated with a transplant**
- ☐ **Request is associated with a clinical trial**

NCT# _____

Diagnosis (ICD -10) Code(s)					
Place of Service *(e.g., Office):*					

CPT/HCPC/REV Code(s)	**Modifier**	**Quantity/Unit**

CPT/HCPC/REV Code(s)	**Modifier**	**Quantity/Unit**

If there are additional CPT codes, please include these on an additional page.

Requesting Provider Information

NPI Number:	**Requesting Provider Name:**	
Tax ID Number:	**Phone:**	**Fax:**
Street Address:		

Servicing Provider Information

NPI Number:	**Requesting Provider Name:**	
Tax ID Number:	**Phone:**	**Fax:**
Street Address:		

Servicing Facility/Practice Information

NPI Number:	**Requesting Provider Name:**	
Tax ID Number:	**Phone:**	**Fax:**
Street Address:		

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.
INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Authorization is not a guarantee of claim payment. The payment for these services is subject to using the authorized provider, your plan eligibility at the time of service, and the benefit limitations in your Certificate of Coverage. Incomplete documentation of the TIN for the servicing provider and/or facility/practice may require additional information to be requested in order for payment to claim to be completed.

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