ALIGN
SENIOR CARE

REQUEST FOR REFERRAL TO SPECIALIST & TELEHEALTH

***Call* UM at 844-205-7244 opt 3 (Call Center Hours M-F 8a– 5p)** ***FAX* Form and Clinical to 833-610-2399**

****** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY***

***PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. (ATTACH OON FORM)** Payment is authorized 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's Plan ID**

_____ _____

Name of Nursing Facility **Referring Provider**

Is Referring Provider: ☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request _____

Service

Date of Procedure/Service: _____**CPT Code or Name of Procedure/Service**: _____

SERVICES REQUESTED

Referral-include copy of order **Out of Network- (ATTACH OON FORM)**

Specialist/HealthCare Professional

Provider Name (REQUIRED): _____

Provider Contact Number (REQUIRED): _____

Provider Specialty (REQUIRED): _____

In Network (REQUIRED): Circle Correct Answer: YES ☐ NO ☐ Number of Visits Requested: _____

Telehealth

Vendor Name (REQUIRED): _____

Vendor Contact Number (REQUIRED): _____

Specialty (REQUIRED): _____

In Network (REQUIRED): Circle Correct Answer: YES ☐ NO ☐ Number of Visits Requested: _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Name of Person Completing this Form: _____ **Date Completed:** _____

(Please Print Name)

Contact #: _____ **Contact FAX:** _____