



REQUEST FOR AUTHORIZATION OF SERVICES FORM

Call UM at: 844-305-3879 (Call Center Hours M-F 8a- 8p)

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.** 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 _____
	Diagnoses (ICD-10 Codes) Related to Auth Request _____		
	Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other		

PART A and OUTPATIENT SERVICE	SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)		
	<input type="checkbox"/> Part A SNF (post hospitalization)	Start Date _____	# of Days Requested _____
	<input type="checkbox"/> Part A Skill-in-Place	Start Date _____	# of Days Requested _____
	<input type="checkbox"/> Additional Part A Days Reason: _____		# of Days Requested _____
	<input type="checkbox"/> Outpatient Diagnostic or Service	Date of Procedure/Service _____	
	CPT Code or Name of Procedure/Service: _____		
	Provider or Facility Name (REQUIRED): _____		
	Provider or Facility Contact Number (REQUIRED): _____		

PART B / THERAPY	REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)		
	<input type="checkbox"/> PT	<input type="checkbox"/> Initial Visits Start of Care: _____ Plan: _____ days per week for _____ week(s) Goals in Place? <input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Additional PT Visits	# requested _____ Plan: _____ days per week for _____ week(s) Goals updated? <input type="checkbox"/> Y <input type="checkbox"/> N	
		Member Actively Participating? <input type="checkbox"/> Y <input type="checkbox"/> N Functional Progress Made? <input type="checkbox"/> Y <input type="checkbox"/> N Demonstrates Potential to Improve? <input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> OT	<input type="checkbox"/> Initial Visits Start of Care: _____ Plan: _____ days per week for _____ week(s) Goals in Place? <input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Additional OT Visits	# requested _____ Plan: _____ days per week for _____ week(s) Goals updated? <input type="checkbox"/> Y <input type="checkbox"/> N	
		Member Actively Participating? <input type="checkbox"/> Y <input type="checkbox"/> N Functional Progress Made? <input type="checkbox"/> Y <input type="checkbox"/> N Demonstrates Potential to Improve? <input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> ST	<input type="checkbox"/> Initial Visits Start of Care _____ Plan: _____ days per week for _____ week(s) Goals in Place? <input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Additional ST Visits	# requested _____ Plan: _____ days per week for _____ week(s) Goals updated? <input type="checkbox"/> Y <input type="checkbox"/> N	
		Member Actively Participating? <input type="checkbox"/> Y <input type="checkbox"/> N Functional Progress Made? <input type="checkbox"/> Y <input type="checkbox"/> N Demonstrates Potential to Improve? <input type="checkbox"/> Y <input type="checkbox"/> N	

*****Part B Therapies Require NP Signature*****

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION	
<input type="checkbox"/> Standard Authorization Request	
<input type="checkbox"/> Expedited Authorization (Must Read and SIGN): By signing below I certify that waiting for a decision longer than 72 hours could place the Member's life, health, or ability to gain maximum function in serious jeopardy.	
Signature for Expedited Review Only: _____	
Name of Person Completing this Form: _____	Date Completed: _____
Contact #: _____	Contact FAX: _____
NP Signature _____	