



CONCURRENT AUTHORIZATION REQUEST FORM

SNP | SIP | IRF | LTACH

Submit this completed form by fax to **1-833-610-2399**, or on our provider portal:

<https://secure.healthx.com/AlignSeniorCare.Provider>

Call California: 1-844-305-3879 (TTY 711), Florida: 1-844-788-8935 (TTY 711), Michigan: 1-855-855-0336 (TTY 711)
to speak with a representative.

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

Routine/Standard Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION

Member Name:	Member ID:
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Date of Birth:	Authorization number:
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CURRENT LEVEL OF CARE

<input type="checkbox"/> SNF	<input type="checkbox"/> Inpatient Rehab	<input type="checkbox"/> LTACH
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CM/SW Name:	Phone Number:	Fax Number:
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Prior Living Conditions:	<input type="checkbox"/> Independent	<input type="checkbox"/> Lives with others	<input type="checkbox"/> SNF	<input type="checkbox"/> ALF/ILF
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Owned DME:	<input type="checkbox"/> Cane (SP/Quad)	<input type="checkbox"/> Walker	<input type="checkbox"/> Rollator	<input type="checkbox"/> W/C	<input type="checkbox"/> Power w/c or Scooter	<input type="checkbox"/> BSC
Other:						

BRIEF CURRENT MEDICAL STATUS UPDATE

Provide brief update on member status/diagnosis/medical condition (If there is a decline, please state reason):	
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Wound Location, size:	Wound treatment/dressing type and frequency:
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IV Antibiotics: please include name/frequency/duration:		
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Name: _____ Frequency: _____ Duration: _____

Name: _____ Frequency: _____ Duration: _____

Name: _____ Frequency: _____ Duration: _____

PT Updates Bed mobility: Transfers: Ambulation:	OT Updates Feeding: Bathing: Dressing: Toileting:	ST Updates: Language/Expression: Cognition: Diet:
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Anticipated Discharge Date:

D/C Barriers:

CLINICAL INFORMATION

- Clinical/ therapy documentation/ assessments should be within 72 hours of request.
- Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.
- Missing this information may delay the decision on your request or may result in Lack of Information denial.

Provider Attestation: By signing below, I certify that the patient's medical records accurately reflect the information provided. I understand that Align Senior Care may request medical records for this patient at any time in order to verify this information. I further understand that if Align Senior Care determines this information is not reflected in the patient's medical records, Align Senior Care may request a refund of any payments made and/or any other remedies available.

Please certify the following by signing and dating below:

Provider Signature: _____ Date: _____

Please fax form to: 1-833-610-2399