

PART B MEDICATION REQUEST FORM

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 it is an emergency, 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:	Member Living Facility:
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REQUESTING PROVIDER/FACILITY

Requestor's Name (Print):	Phone Number:	Fax Number:
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Referring Provider (If other than requestor):	Referring Provider: <input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other
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NPI/PIN number:	Date of Request:
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SERVICING PROVIDER/FACILITY

Admitting/ Servicing Facility/ Provider Name:		
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NPI/ PIN Number:	Phone Number:	Fax number:
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Address:		
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City:	State:	Zip:
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MEDICATION REQUESTED

<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension Request, Previous Auth #:
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Place of service:	<input type="checkbox"/> Home Infusion	<input type="checkbox"/> Office	<input type="checkbox"/> Outpatient Hospital	<input type="checkbox"/> Specialty Pharmacy
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Specialty Pharmacy:	Home Infusion:
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Days/ Visits/ Units Requested:	Date of Service:
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HCPCS Code(s):	CPT/Other billing code:
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Drug requested:	NDC:
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Dosage:	Frequency/Duration:
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Current Primary Diagnoses and ICD-10 Code (s):

CLINICAL INFORMATION

- Please submit written documentation from the medical record to support the procedure, including photos when applicable.
- Missing this information may delay the decision on your request or may result in Lack of Information denial.
- Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, et

OUT-OF-NETWORK SERVICES ONLY

- Has the service been scheduled already? Yes No
- Is this a specialized service that no other In-network provider can render? Yes No
- Does the member have an established relationship with the provider that should not be interrupted?
Yes No

If "Yes", explain (include last visit date):

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