

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:	
Date of Birth:	Member Living Facility:		
REQUESTING PROVIDER/FACILITY			
Requestor's Name (Print):	Phone Number:	Fax Number:	
Referring Provider (If other than requestor):	Referring Provider: ☐ NP/PA ☐ PCP ☐ Therapy Rep ☐ Other		
NPI/PIN number:	Date of Request:		
SERVICING PROVIDER/FACILITY			
Admitting/ Servicing Facility/ Provider Name:			
NPI/ PIN Number:	Phone Number:	Fax number:	
Address:			
City:	State:	Zip:	
MEDICATION REQUESTED			
☐ Initial Request ☐ Extension Request, Previous Auth #:			
Place of service: ☐ Home Infusion ☐ Office ☐ Outpatient Hospital ☐ Specialty Pharmacy			
Specialty Pharmacy:		Home Infusion:	
Days/ Visits/ Units Requested:		Date of Service:	
HCPCS Code(s):		CPT/Other billing code:	
Drug requested:		NDC:	
Dosage:		Frequency/Duration:	

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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