ALIGN
SENIOR CARE

REQUEST FOR REFERRAL TO SPECIALIST, PSYCHIATRY, TELEHEALTH AND OTHER HEALTHCARE PROFESSIONAL

Call UM at: 844-305-3879 (CA), 844-788-8935 (FL), 855-855-0336 (MI), 844-854-6885 (OR) or 855-855-0489 (VA)
(Call Center Hours: 8am – 8pm LOCAL TIME)

FAX Form and Clinical to 833-610-2399

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. *** PLEASE INCLUDE ONLY ONE MEMBER PER SUBMISSION.***

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 **PA-include clinical** **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:** _____