

REQUEST FOR AUTHORIZATION OF SERVICES FORM

Call UM at 844-854-6886 (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 _____ Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other
	Diagnoses (ICD-10 Codes) Related to Auth Request _____
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 Date of Eval _____ 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 Date of Eval _____ 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 Date of Eval _____ 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

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Standard Authorization Request

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: _____
(Please Print Name)

Contact #: _____ Contact FAX: _____