# PRIOR AUTHORIZATION REQUEST FORM

Submit this completed form by fax to **1-833-610-2399,** or on our provider portal:
**https://secure.healthx.com/NHCAdvantage.Provider**
Call 1-844-854-6886 (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 Residence: | | |
| **REQUESTING PROVIDER/FACILITY** | | | |
| Requestor's Name: | Phone Number: | Fax Number: | Date of Request: |
| Referring Provider (If other than requestor): | Referring Provider:<br>☐NP/PA ☐PCP ☐Therapy Rep ☐Other | | |
| **SERVICING PROVIDER/FACILITY** | | | |
| Admitting/ Servicing Facility/ Provider Name: | | | |
| NPI/ TIN Number: | Phone Number: | Fax number: | |
| Address: | | | |
| City: | State: | Zip: | |
| **SERVICE TYPE REQUESTED** | | | |
| ☐Initial Request ☐ Extension Request, Previous Auth #: | | | |
| Outpatient Services (Select one): | | | |
| ☐ Durable Medical Equipment (DME)<br>☐Genetic Testing<br>☐Home Health<br>☐Imaging/Special Tests<br>☐Office Procedures | ☐Laboratory Services<br>☐Outpatient Surgical/Procedures<br>☐Radiation Therapy<br>☐Transplant/Gene Therapy<br>☐Transportation | ☐PT/OT/ST<br>☐Wound Care<br>☐Part B Medication<br>☐Behavioral Health Services<br>☐Other | |
| Days/ Visits/ Units Requested: | Admission Date/ Date of Service: | | |
| CPT/HCPCS Code(s): | | | |
| Current Primary Diagnoses and ICD-10 Code (s): | | | |

| CLINICAL INFORMATION |
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| • Please submit written documentation from the medical record to support the procedure, including photos when applicable.<br>• Missing this information may delay the decision on your request or may result in Lack of Information denial.<br>• Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc. |
| **OUT-OF NETWORK SERVICES ONLY** |
| • Has the service been scheduled already? ☐ Yes ☐ No<br>• Is this a specialized service that no other In-network provider can render? ☐Yes ☐No<br>• Does the member have an established relationship with the provider that should not be interrupted? ☐ Yes ☐No<br>If "Yes", explain (include last visit date): |