Provider Partners Health Plans

Auth. Submission Fax: (844) 593-6221

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. Payment 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 ID _____

Nursing Facility _____

Ordering Provider _____ Phone #: _____ Fax #: _____

Primary Diagnosis (ICD-10 Code # & Description) _____

Requesting Facility Name:

Requesting Facility Address:

Requesting Facility Phone#: _____ Requesting Facility Fax #: _____

Requesting Facility NPI#: _____

AUTHORIZATION REQUEST

SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)

☐ SNF Part A ☐ DME ☐ Inpatient ☐ Continuation/Additional Days

☐ Specialist Visit Specialist Type: _____ Name: _____ Office Phone: _____

Diagnostic Testing or Procedure (List Type, CPT code w/description) _____

List Requesting Provider Name: _____

Requesting Provider Address: _____

Start Date/End Date: _____ Service: _____

Requesting Provider NPI#:

THERAPY REQUEST

REQUEST FOR THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes for Part B)

Request for ☐ PT ☐ OT ☐ ST ☐ Other _____

☐ Therapy Treatment Plan ☐ Additional Therapy Days ☐ In Progress

Start date of Services: _____ Date of Initial Evaluation: _____ Date of Last Exam _____

# of PT Therapy Days Requested: _____ _____ Times per week For _____ weeks

# of OT Therapy Days Requested: _____ _____ Times per week For _____ weeks

# of ST Therapy Days Requested: _____ _____ Times per week For _____ weeks

List of CPT Codes: _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** CMS allows 14 days for standard authorizations. Our goal is 5-7 days.

☐ **Expedited Authorization (Must Read and SIGN):** By signing below I certify that waiting for a decision under the standard time frame could place the Member's life, or health in serious jeopardy.

SIGNATURE: _____

Name of Person Completing this form: _____ Date Completed: _____

Contact #: Authorization Notification FAX:

This authorization is **NOT** a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.