FAX THIS FORM TO 1-800-880-3263, or Intake@SignatureAdvantagePlan.com

REQUEST FOR AUTHORIZATION OF SERVICES

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 ____________ Health Plan ID ____________

Nursing Facility ____________ Referring Provider ____________ Is Referring Provider: ☐ Plan NP ☐ NFist/PCP ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request ____________

AUTHORIZATION/REFERRAL REQUEST

SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests) Check if: ☐ Out-of-Network

☐ Observation Status ☐ Inpatient Admission (☐ Emergent ☐ Scheduled) ☐ Procedure ____________

☐ Skilled Nursing Care Post-Hospital or ER Reason ____________ Number of Days Requested ____________

☐ Skill-in-Place (SIP) Services Reason ____________ Number of Days Requested ____________

G-CODE (Circle One) **G9679 Pneumonia** **G9680 CHF** **G9681 COPD/Asthma** **G9682 Skin Infection** **G9683 Fluid/Electrolyte Disorder** **G9684 UTI**

☐ Specialist Referral Name ____________ Specialty Type ____________ Office Number ____________

☐ **Consult Only** Appointment Date: ____________ (If known)

☐ Treatment as recommended ______ times per ____________ (Day/Week/Month) for _____ visits. Start Date ____________

☐ Durable Medical Equipment ____________ ☐ Expect to exceed $250 billed charges each month

☐ Diagnostic Testing or Procedure (List Type and CPT CODE) ____________

☐ In Facility ☐ Out of Facility List Provider/Facility: ____________

Scheduled Date for Services (if scheduled) ____________

☐ Transportation Services to: ☐ Physician Office ☐ OP Services/Testing ☐ Other: ____________

☐ Facility Van ☐ Outside Provider (List Name) ____________

PART B THERAPY REQUEST

REQUEST FOR PART B THERAPY SERVICES (Attach care plan, initial evaluation, and most recent therapy notes)

Note: Authorization Not Required for PT, OT, ST in contracted nursing facility.

Request is for ☐ PT ☐ OT ☐ ST ☐ Other ____________

☐ Initial Evaluation ☐ Therapy Treatment Plan ☐ Additional Therapy Days ☐ In Progress

Date of injury/illness: ____________ Date of Initial Evaluation: ____________ Date of Last Exam: ____________

# of Therapy Days Requested: ____________ ________ Times per week For ____________ weeks

Reason for Request: ____________

Significant Improvement Has Been Made ☐ Yes ☐ No Rehab Potential ☐ Fair ☐ Good ☐ Excellent

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** Most services if requested by or with a written order from a PCP or Plan NP are "auto-authorized" within 8 hours or less. CMS allows 14 days for standard authorizations. Our goal is within 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, health, or ability to gain maximum function in serious jeopardy.

Signature ____________

Name of Person Completing this Form: ____________ **Date Completed:** ____________

Contact #: ____________ **Contact FAX:** ____________

PCP/NP SIGNATURE: ____________ **(Required)**