FAX THIS FORM TO 1-800-880-3263 or
SaIntake@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)

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

☐ Skill-in-Place services Reason _____ Number of Days Requested _____

G-CODE (Circle One) **G9679 Pneumonia** **G9680 CHFG9681 COPD/Asthma** **G9682 Skin Infection** **G9683 Fluid/Electrolyte Disorder** **G9684 UTI**

☐ Durable Medical Equipment _____

☐ Specialist Referral Name Office Number

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

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

☐ Transportation Services:

☐ Facility Van ☐ Outside Provider (List Name) _____

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

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

Scheduled Date for Services (if scheduled) _____

THERAPY REQUEST

REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes) **No Auth Required for PT, OT, ST in contracted nursing facility.**

Request 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 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)**