Signature Advantage

Auth. Submission Fax: (800) 880-3263

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

AUTHORIZATION REQUEST

Member Name _____ DOB _____ Member ID _____

Nursing Facility _____

Requesting Provider / Type _____ NPI: _____

Phone #: _____ Fax #: _____

Primary Diagnosis _____

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

Servicing Provider/Facility: _____ Tax ID #: _____

Servicing Provider Phone #: _____ Servicing Provider Fax #: _____

(Include all Clinical Documentation with request)

☐ SNF (After Discharge) ☐ Inpatient Admit ☐ Behaviorial Health ☐ Outpatient Services ☐ SIP (Skill in Place) Start Date _____

☐ Home Health ☐ DME: Rental or Purchase (circle one) Office Visit: ☐ New Patient ☐ Follow/up

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

List Provider/Facility: _____

Scheduled Date for Services (if Scheduled) _____

CPT Codes & Quantities: _____

THERAPY REQUEST

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

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: _____ _____ Times per week For _____ weeks

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

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

List of CPT Codes: _____

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, or health in serious jeopardy.

SIGNATURE: _____ Date Completed: _____

Name of Person Completing this form: _____

Notification will be faxed upon determination. Please complete the following for notification of decision.

Who is Receiving Authorization Notification FAX: _____

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.

This facsimile message is privileged and confidential. It is transmitted for the exclusive use of the addressee. This communication may not be copied or disseminated except as directed by the addressee. If you have received this communication in error, please notify us immediately.