NOTIFICATION/PRIOR APPROVAL FORM

Fax completed form to Utilization Management (UM) to 877-314-5693

MEMBER INFORMATION *(*Denotes required field)*		
*Patient name:	*☐ Male *☐ Female	*DOB:
*Health Insurance ID#:	Other Health Insurance (please specify):	
Address:	Phone:	

☐ **Routine** ☐ **Urgent** (Could seriously jeopardize the Member's life or health, ability to regain maximum function, or subjects Member to severe pain that cannot be adequately managed without the requested care or treatment)

May Call UM 24/7 (855) 542-0880

PROVIDER INFORMATION	
*Requesting/Ordering Provider:	*Servicing Provider/Facility:
*Name:	*Name:
*Address:	*Address:
*Tel:	*Tel:
*Fax:	*Fax:
*Contact Person:	*Specialty:
*Contact Tel:	*NPI:
*NPI	☐ Servicing Provider/Facility same as requesting

Clinical Summary or clinical notes *must* be attached. Incomplete information may delay decision process.

REQUESTED SERVICE(S) REQUIRING NOTIFICATION *(Check all that apply)*	
In-Network Home Health** ☐ Home Health (Please Check): ☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ Social Work *** Home Health visits will be approved up to three (3) visits with notification on or before day of first visit.* ***Clinical must be submitted within there (3) business days of first visit.*** **	In-Network Inpatient Care/Observation ☐ Observation ≤ 24 hours ☐ Acute Medical/Surgical ☐ Skilled Nursing Facility (SNF) ** ☐ Acute Rehabilitation Facility (ARF) ** *** SNF and ARF will be approved up to (seven) 7 days based on Provider orders with notification on or before admission date.* ***Clinical must be submitted within three (3) business days of admission***. ** **Call: (855) 542-0880 for notification.**

DIAGNOSIS INFORMATION *(*Denotes required field)*	
***ICD10 (List codes <u>AND</u> description):**	
1.	3.
2.	4.

PLANNED PROCEDURE INFORMATION *(*Denotes required field)*

*Procedure/Service requested (list all CPT/HCPC Codes AND Description required)

☐ INPATIENT PROCEDURE/SURGERY ☐ OUTPATIENT PROCEDURE/SURGERY ☐ INJECTION/INFUSION >$400

☐ OUTPATIENT PT/OT/ST/CHIRO ☐ HOSPICE ☐ ALL OUT OF NETWORK SERVICES ☐ TRANSPORTATION (Air/Ground)

**** For injections/infusions # of units = # of doses requested during dates of service.****

CPT/HCPCS CODE	DESCRIPTION	# OF UNITS OR VISITS	CPT/HCPCS CODE	DESCRIPTION	# OF UNITS OR VISITS
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

*Date(s) of service/ planned procedure/admission:

Start: End:

DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES *(*Denotes required field*)

The Plan provides for the least expensive equipment necessary to meet the medical needs

*Type of Request ☐ Rental (Quantity is requested in months) ☐ Purchase ☐ Replacement

Item Code	Item Description	Quantity Requested	Billed Price Per Unit	Total Billed Amount	Least Expensive Option Y/N

*Date(s) of service of rental/ date of purchase otherwise:

Start: End: