Community HEALTH OPTIONS®

Therapies Notification/Prior Approval Form

(Chiro, OMT & Outpatient PT, OT, ST)

Fax completed form to Medical Management to (877) 314-5693

Effective date: 11/1/2018

Member Information (*Denotes Required Field)		
*Patient Name:	*☐ Male *☐ Female	*DOB:
*Health Insurance ID#:	Other Health Insurance (please specify):	
Address:	Phone:	

☐ **Routine** ▸ Routine Pre-Service requests are generally processed within two business days of receipt of all necessary information.

☐ **Urgent** ▸ Urgent Pre-Service requests are processed within two calendar days. Urgent requests are based on clinical presentations that could seriously jeopardize the Member's life or health, ability to regain maximum function, or subjects the Member to severe pain that cannot be adequately managed without the requested care or treatment. To initiate urgent referrals by phone 24/7 call (855) 542-0880.

Emergency services (911 ambulance transport and ED evaluation/treatment) do not require Prior Approval.

Provider Information	
***Requesting/Ordering Provider:**	☐ ***Servicing/Rendering Provider or Facility Same as Requesting/Ordering Provider**
*Name:	*Name:
*Address:	*Address:
*Tel:	*Tel:
*Fax:	*Fax:
*Contact Person:	*Specialty:
*Contact Tel:	*NPI:
*NPI	Please list additional provider information, if applicable, to include name, NPI & location.
Clinical Summary or clinical notes must be attached. Incomplete information may delay decision process.	

Diagnosis Information (*Denotes Required Field)	
*ICD10 (List codes AND description):	
1.	3.
2.	4.

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

CPT/HCPCS Code	Brief Description	CPT/HCPCS Code	Brief Description
1.		4.	
2.		5.	
3.		6.	

Chiro, OMT combined visits this calendar year (performed by provider and/or reported by patient): _____

PT, OT, ST combined visits this calendar year (performed by this provider and/or reported by patient): _____

continued

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PLEASE NOTE: Maximum of 12 visits per request.
Authorization date range defaults to 60 calendar days; providers can request shorter/longer date ranges.
Maximum of 12 visits/3 weeks or 24 visits/8 weeks.
All authorizations end by 12/31 of each calendar year; providers can submit requests as of 12/15 for 1/1 or later dates of service.

Chiropractic/Osteopathic Services	Physical, Occupational, Speech Therapies (Applies to outpatient services only)
Notification/Prior Approval is required within ten (10) business days of the first treatment or continued treatment.	
☐ Initial Notification (visits 1-12) Number of visits: _____ Attach a summary of Member's complaint(s), related history, examination, initial diagnosis, and treatment plan. Dates of service (include 1st treatment date): Start_____/_____/_____ End _____/_____/_____	☐ Initial Notification (visits 1-12) Number of visits: _____ Attach a summary of Member's complaint(s), related history, examination, initial diagnosis, and treatment plan. Dates of service (include 1st treatment date): Start_____/_____/_____ End _____/_____/_____
☐ Notification (visits 13-24) Number of visits: _____ Attach an updated treatment plan. Patient's condition is improving. ☐ YES ☐ NO (If NO, submit information indicating how you have changed the treatment plan.) Dates of service: Start_____/_____/_____ End _____/_____/_____	☐ Prior Approval (visits 13-60) Number of visits: _____ Attach clinical notes with an updated treatment plan to support ongoing medical necessity. Patient's condition is improving. ☐ YES ☐ NO (If NO, submit information indicating how you have changed the treatment plan.) Dates of service: Start_____/_____/_____ End _____/_____/_____ ***2019 Benefit Limit: 60 combined PT/OT/ST visits.***
☐ Prior Approval (visits 25-40) Number of visits: _____ Attach clinical notes with an updated treatment plan to support ongoing medical necessity. Patient's condition is improving. ☐ YES ☐ NO (If NO, submit information indicating how you have changed the treatment plan.) Dates of service: Start_____/_____/_____ End _____/_____/_____ ***2019 Benefit Limit: 40 combined Chiro/OMT visits.***	*NOTE:* *This form only applies to PT, OT, ST services that are provided in the outpatient setting. It does not include home health or inpatient services.* *Please see the Notification/Prior Approval form for Home Health Services requests.*

Fax completed form with clinical notes to Medical Management (877) 314-5693
If submitting via Provider Portal, please upload this document with clinical notes.