Community HEALTH OPTIONS®

Notification/Prior Approval Form

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

Updated: 11/1/2019

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 will generally be processed within 72 hours or two business days, whichever is earliest, upon receipt of all medically necessary information.

☐ **Urgent** ▸ Urgent Pre-Service requests will generally be processed within one calendar day of receipt of all necessary information. 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:**
*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.

Requested Service(s) Requiring Notification (Check All That Apply) NOTE: HMO coverage is limited to in-network services.

☐ Home Health (Please check all that apply):
☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ SW

In-network: Notification is required within 48 hours of first home visit.

Out of network: Requires approval prior to the 1st home visit.

☐ Observation Stays & Admissions (Require medical necessity review of the entire stay.)

☐ Observation Stay: Notification is required within 48 hours. Note: Admit or discharge within 48 hours.

☐ Acute Inpatient Admission - Notification is required within 48 hours.

☐ Acute Rehabilitation Facility (ARF) - Notification is required within three (3) BD.

☐ Skilled Nursing Facility (SNF) - Notification is required within three (3) BD.

☐ Long Term Acute Care Hospital (LTACH)- Approval is required prior to admission.

Diagnosis Information (*Denotes Required Field)	
*ICD10 (List codes AND description):	
1.	4.
2.	5.
3.	6.

continued

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Planned Procedure Information (*Denotes Required Field)

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

☐ **Outpatient procedure/surgery**

☐ **Inpatient procedure/surgery**
Notification by facility is required within 48 hours of admission.

☐ **Transportation (Air/Ground/Water)**
Transport coverage is limited to the nearest medical facility licensed and capable of providing the medically necessary level of care.

☐ **Out-of-network (OON) services**
For all OON Services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage.

☐ **Hospice**

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 (submit CPAP/BIPAP compliance report for CPAP/BIPAP purchase request
☐ Replacement (include date of initial purchase & product serial number)

Item Code	Item Description	Quantity Requested	Billed Price Per Unit	Total Billed Amount	"X" confirms least expensive option to meet needs (required)

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

Start: End:

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