COMMUNITY Health Options™

Notification/Prior Approval Form

Submit authorization requests via: Provider Portal (preferred): Provider.HealthOptions.org Health Options (Medical Management): Updated: 1/1/2022
Fax: (877) 314-5693 Phone: (855) 542-0880

Member Information (*Denotes Required Field)

*Member 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.

Procedure Information – Requires submission of written clinical information with request.

AMBULATORY/OUTPATIENT PROCEDURE

Ambulatory/Outpatient Procedures
Requests must be submitted within 10 business days (BD) of date of service.

☐ **Ambulance transportation** (Routine/Urgent)
Coverage is limited to nearest facility.
Nearest facility ☐ Yes ☐ No
If no, submit clinical rationale.
Interfacility transport requires notification prior to transport.

☐ **Colonoscopy**
If preventive: ☐ Initial ☐ Routine follow-up
Date of last colonoscopy: _____

☐ **Home Health**
In-network- PA required after 1st visit.
Out-of-network: PA required before 1st visit.
Check all that apply:
☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ SW
☐ MD ☐ NP ☐ PA

☐ **Hospice**

☐ **Outpatient procedure/surgery**

Service: _____

See separate PA forms:

- Behavioral Health Services
- Medical Benefit Drugs

Admissions: Medical Necessity review applies to the entire stay unless otherwise specified

Acute Care: Admission/Observation Stay

Notification is required within 48 hours (or by 12 noon the first BD following a weekend/holiday observation stay/admission even if already discharged).

Applies to scheduled, elective admissions, and admissions from the Emergency Department (ED).

□ **Acute Care: Inpatient Admission**

Admissions from the ED are subject to clinical review of the entire stay to determination stabilization and support discharge coordination.

□ **Acute Care: Observation Stay**

Observation is limited to 48 hours; admit or discharge to lower level of care.

See separate PA form:

- Behavioral Health Services

ARF and SNF In-network Admissions

Medical necessity review is waived for bed days prior to notification if notification is completed within 3 business days (BD) of admission.

Acute Rehabilitation Facility (ARF)

□ In-network: Notification required within 3 BD.
□ Out-of-network: Must obtain Prior Approval.

Long Term Acute Care Hospital (LTACH)

□ Must obtain Prior Approval. All admissions. Medical necessity review applies to entire stay.

Skilled Nursing Facility (SNF):

□ In-network: Notification required within 3 BD.
□ Out-of-network: Must obtain Prior Approval. Medical necessity review applies to entire stay.

Diagnosis Information (*Denotes Required Field)

*ICD10 (List codes AND description):

1.	4.
2.	5.
3.	6.

CPT/HCPCS Code	Description: List primary procedure first	#of units or visits within 90 days	CPT/HCPCS Code	Description	#of units or visits within 90 days
1. (primary procedure)			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

*Date(s) of service/planned procedure/admission (Preservice approvals are limited to 90 days)

Start: End:

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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, typically limited to 3 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:

Out-of-Network (OON) Services: Please advise Member to call Member Services at (855) 624-6463 to inquire about OON coverage.