Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THE "STANDARDIZED PRIOR AUTHORIZATION FORM".
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.

The Standardized Prior Authorization Form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements. For payer specific policies, please reference the payer specific websites.

Health Plan:	**Health Plan Fax #:**	***Date Form Completed and Faxed:**
Commonwealth Care Alliance	855-341-0720	10/10/2020

Service Type Requiring Authorization[1, 2, 3] (*Check all that apply*)

Ambulatory/Outpatient Services	**Ancillary**	**Dental**	**Durable Medical Equipment**
☑ Surgery/Procedure (SDC) ☐ Infusion or Oncology Drugs	☐ Acupuncture ☑ Chiropractic ☐ IVF/ART ☐ Non-Participating Specialist	☐ Adjunctive Dental Services ☐ Endodontics ☐ Maxilliofacial Prosthetics ☐ Oral Surgery ☐ Restorative	☐ Prosthetic Device ☐ Purchase ☐ Renal Supplies ☐ Rental
Home Health/Hospice	**Inpatient Care/Observation**	**Nutrition/Counseling**	**Outpatient Therapy**
☐ Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) ☐ Hospice ☐ Infusion Therapy ☐ Respite Care	☐ Acute Medical/Surgical ☐ Long Term Acute Care ☐ Acute Rehab ☐ Skilled Nursing Facility ☐ Observation	☐ Counseling ☐ Enteral Nutrition ☐ Infant Formula ☐ Total Parental Nutrition	☐ Occupational Therapy ☐ Physical Therapy ☐ Pulmonary/Cardiac Rehab ☐ Speech Therapy
Transportation ☐ Non-emergent Ground ☐ Non-emergent Air	☐ **Other—please specify:** sdfsdf		

Provider Information (**Denotes required field*)

***Requesting Provider Name and NPI#:**	***Phone:**	**Fax:**
sdfdsf	dsfsdf	sdfsdf
***Servicing Provider Name and NPI# (and Tax ID if required):** ☐ *Same as Requesting Provider*	***Phone:**	**Fax:**
***Servicing Facility Name and NPI#:** ☐ *Same as Requesting Provider*	***Phone:**	**Fax:**
***Contact Person:**	***Phone:**	**Fax:**

Member Information (**Denotes required field*)

***Patient Name:**	***☐ Male ☐ Female**	***DOB:**
Health Insurance ID#:** ***If other insurance, please specify:	***Patient Account/Control Number:**	
Address:	**Phone:**	

Diagnosis/Planned Procedure Information (**Denotes required field*)

***Principal Diagnosis Description:** **ICD-9 Codes:**	***Principal Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** ☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage
Secondary Diagnosis Description: **ICD-9 Codes:**	**Secondary Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** ☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage
***Service Start Date:**	***Service End Date:**

[1] Please attach plan specific templates that are required for supporting clinical documentation.
[2] Not all services listed will be covered by the benefits in a member's health plan product.
[3] This form does not replace payer specific prior authorization requirements.

Clear Form