MEDICAL SERVICES
Medicare D-SNP Pre-Authorization Fax: 713-295-7059
Admissions Notification Fax: 713-295-2284
Complex Care Fax: 713-295-7016

BEHAVIORAL HEALTH SERVICES

Medicare
Pre-Authorization OP Fax: 713-576-0930
Pre-Authorization IP Fax: 713-576-0930

COMMUNITY HEALTH CHOICE

***Failure to Complete All Applicable Fields May Delay Processing***

# AUTHORIZATION REVIEW FORM FOR HEALTH CARE SERVICES

## SECTION I – SUBMISSION

| Issuer Name: | Phone: | Fax: | Request Date: |
|---|---|---|---|
| AVLT Healthcare | (245) 789-6750 | (123) 456-7891 | 08/24/2022 |

## SECTION II – GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent — Clinical Reason for Urgency:

Request Type: ☐ Initial Request ☐ Extension ☐ Amendment — Prev. Auth. #:

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery Other: _____

## SECTION III - PATIENT INFORMATION

| Name: | Phone: | DOB: | ☑ Male ☐ Other | ☐ Female ☐ Unknown |
|---|---|---|---|---|
| Member 901 | (490) 735-6000 | 11/09/1980 | | |

| Subscriber Name (if different): | Member or Medicaid ID #: | Plan Name: |
|---|---|---|
| | ABCD543 Sub | CMC |

## SECTION IV - PROVIDER INFORMATION

| Requesting Provider or Facility | | Service Provider or Facility | |
|---|---|---|---|
| Name: Dr. Keith Hamilton | Tax ID: | Name: Dr. Andrew Jade | Tax ID: |
| NPI #: 8241537812 | Specialty: | NPI #: 5432126453 | Specialty: |
| Phone: | Fax: | Phone: | Fax: |
| Contact Name: | Phone: | Primary Care Provider Name (see instructions): | |
| Requesting Provider's Signature and Date: | | Phone: | Fax: |

## SECTION V - SERVICES REQUESTED (WITH CPT, CDT, REV OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No Nursing Assessment Attached? ☐ Yes ☐ No)

☐ DME (MD Signed Order Attached? Yes ☐ No ☐ Title 19 Certification Attached? *(Medicaid Only)* Yes ☐ No ☐

Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

☐ Other Services: _____

| Planned Service or Procedure | Code (CPT, HCPCS, Revenue Code) | Units | Start Date | End Date | Diagnosis Description | ICD-10 Code |
|---|---|---|---|---|---|---|
| office visit / established Patient | 99212 | 1 | 08/24/2022 | 08/24/2022 | Diabetes Mellitus | E08.01 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

***An issuer needing more information may call the requesting provider directly at:*** _____

***** Required: Attach clinical documentation to this form upon submission.*****