AUTHORIZATION SUBMISSION FAX: 888-300-9320

CommuniCare ADVANTAGE

REQUEST FOR AUTHORIZATION OF SERVICES - ISNP

PARTICIPATING PROVIDERS: Please refer to Section III for the list of services that require prior authorization.
NON-PARTICIPATING PROVIDERS: Prior authorization is required for all services with exception of emergent, urgent care, and observation. Payment is only for the medical services noted below and is subject to the limitations and exclusions in the Member Handbook/Certificate of Coverage.

Section I: Member Information

Member Name: _____ Date of Birth: _____ Member ID: _____

Ordering Provider: _____ Phone No.: _____ Fax No.: _____

Primary Diagnosis (ICD-10 and Description): _____

Reason for Service Request: _____

Section II: Requesting Provider/Requesting Facility Information

Rendering Facility Name _____ Street Address _____

Facility Phone _____ City, ST, ZIP _____

Facility Fax _____ Facility NPI _____ Facility Tax ID _____

Rendering Provider Name _____ Street Address _____

Provider Phone _____ City, ST, ZIP _____

Provider NPI _____ Provider Tax ID _____

Section III: Services Requested (include copy of order or clinical note)

Start Date: _____ End Date: _____

- ☐ Abortion
- ☐ Acute Rehabilitation Facility
- ☐ Air Ambulance
- ☐ Ambulatory Surgery Center
- ☐ Behavioral Health
  - ☐ Inpatient
  - ☐ Partial Hospital
  - ☐ Neurological Testing
  - ☐ Psychological Testing
- ☐ Chemotherapy (>$1,000) (injectable drugs)
- ☐ Clinical Trials (not approved by Medicare)
- ☐ Dental Services
- ☐ Diabetic Shoes (>$1,000)
- ☐ DME (>$500)
- ☐ Enteral/Parenteral Feeding (>$1,000)
- ☐ Experimental/Investigational Procedures
- ☐ Genetic Testing
- ☐ Home Health Services
- ☐ Hospice (Notification Only)
- ☐ Hospital – Inpatient
- ☐ Hospital – Long-Term Acute Care
- ☐ Hospital – Outpatient Surgery
- ☐ Hyperbaric Oxygen Therapy
- ☐ Implantable Pump, Device, Stimulator
- ☐ Infusion Therapy
- ☐ Medical Nutrition Education
- ☐ Medical supplies (>$1,000) (except diabetic supplies)
- ☐ MOHS Procedure (Dermatology)
- ☐ **Non-Participating Provider**
- ☐ Opioid Treatment
- ☐ Outpatient Hospital (excludes labs, ultrasounds, x-rays)
- ☐ Pain Management
- ☐ Part B Drugs (>$1,000)
- ☐ Prosthetics/Orthotics (>$1,000)
- ☐ Radiation Therapy/Radiation Oncology
- ☐ Radiology/Diagnostic Test: Cardiac, CT, CTA, Echo, MRA, MRI, Nuclear Med, PET, Pill, MUGA, Medical Oncology, Virtual Colonoscopy or Endoscopy and 3-D Ultrasounds
- ☐ Rehab Therapy: PT, OT, ST, Outpatient, and Office
- ☐ Rehab: Cardiac/Pulmonary/Respiratory
- ☐ Skilled Nursing Facility
- ☐ Sleep Study
- ☐ Sterilization
- ☐ Substance Abuse Treatment
- ☐ TMJ Treatment
- ☐ Transplant
- ☐ Wound Care (outpatient hospital only)

REQUEST FOR AUTHORIZATION OF SERVICES, continued

CPT or HCPC Code(s)	Description	# of Visits/Injections

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization**: Authorizations will be processed within 14 days of receipt.

☐ **Expedited Authorization (Must Read and SIGN)**: By signing below, I certify that waiting for a decision under the standard time frame could place the Member's life or health in serious jeopardy.

SIGNATURE:

Name of Person Completing this Form:

Date Completed:

Contact #:

Authorization Notification Fax:

To check on the status of an authorization or for other questions, please call Provider Services at 855-969-5861.

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.