AUTHORIZATION SUBMISSION FAX: 888-300-9320

CommuniCare ADVANTAGE

REQUEST FOR AUTHORIZATION OF SERVICES

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

Facility Name _____ Street Address _____

Facility Phone _____ City, ST ZIP _____

Facility Fax _____ Facility NPI _____ Facility Tax ID _____

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
- ☐ Ambulance (for non-emergency transport)
- ☐ Ambulatory Surgery Center
- ☐ Behavioral Health
  - ☐ Inpatient
  - ☐ Outpatient and Partial Hospital
  - ☐ Neurological Testing
  - ☐ Psychological Testing
- ☐ Chemotherapy
- ☐ Clinical Trials (not approved by Medicare)
- ☐ Dental Services
- ☐ Diabetic Shoes
- ☐ Dialysis
- ☐ DME (ISNP – all; CSNP >$250)
- ☐ Enteral Feeding
- ☐ Experimental/Investigational Procedures
- ☐ Genetic Testing
- ☐ Home Health Services
- ☐ Hospice (Notification Only)
- ☐ Hospital – Inpatient
- ☐ Hospital – Long-Term Acute Care
- ☐ Hyperbaric Oxygen Therapy
- ☐ Implantable Pump, Device, Stimulator
- ☐ Infusion Therapy
- ☐ Medical Nutrition Education
- ☐ Medical supplies >$500 (except diabetic supplies)
- ☐ MOHS Procedure (Dermatology)
- ☐ Non-Participating Provider
- ☐ Obstetrical Care
- ☐ Opioid Treatment
- ☐ Orthotics >$250
- ☐ Outpatient Hospital (excludes labs, ultrasounds, x-rays)
- ☐ Pain Management
- ☐ Prosthetics
- ☐ Radiation Therapy/Radiation Oncology
- ☐ Radiology/Diagnostic Test: Barium Enema, 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
- ☐ 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 timeframe 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:

For ISNP: 855-969-5861
For CSNP: 855-969-5869

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.