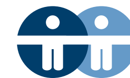

CommuniCare ADVANTAGE

AUTHORIZATION SUBMISSION FAX: 888-300-9320

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. 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 Number ____________ Fax Number ____________
Primary Diagnosis (ICD-10 & Description): ____________

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 for out-of-network requests)

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)
- ☐ Hyperbaric Oxygen Therapy
- ☐ Implantable Pump, Device, Stimulator
- ☐ Infusion Therapy
- ☐ Injections >$100 billed charges per unit
- ☐ Inpatient Hospital
- ☐ Long Term Acute Care Hospital (LTAC)
- ☐ Medical Nutrition Education
- ☐ Medical supplies >$250 (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: CT, CTA, Echo, MRA, MRI, Nuclear Med, Cardiac, PET, Pill, MUGA, Medical Oncology, Virtual Colonoscopy or Endoscopy and 3-D Ultrasounds
- ☐ Rehab: Cardiac/Pulmonary/Respiratory
- ☐ Rehab Therapy: PT, OT, ST, Outpatient and Office
- ☐ Skilled Nursing Facility
- ☐ Sleep Study
- ☐ Sterilization
- ☐ TMJ Treatment
- ☐ Transplant
- ☐ Wound Care (outpatient hospital only)

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

CONTINUED

REQUEST FOR AUTHORIZATION OF SERVICES, continued

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:

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.

This facsimile message is privileged and confidential. It is transmitted for the exclusive use of the addressee. This communication may not be copied or disseminated except as directed by the addressee. If you have received this communication in error, please notify us immediately.