AUTHORIZATION SUBMISSION FAX: 1-866-439-0065

CommuniCare ADVANTAGE

REQUEST FOR AUTHORIZATION OF SERVICES - CSNP

PARTICIPATING PROVIDERS: Please refer to Section III for the list of services that require prior authorization.
NON-PARTICIPATING PROVIDERS: Please refer to Section III for the list of services that require prior authorization. An authorization is not a guarantee of payment and is only for the services indicated below. Payment is subject to the limitations and exclusions as outlined in the Member Evidence 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: _____

- ☐ Acute Rehabilitation Facility
- ☐ Air Ambulance
- ☐ Durable Medical Equipment (DME) (>$500)
- ☐ Home Health Services
- ☐ Hospital
  - ○ Inpatient
  - ○ Long-Term Acute Care (LTAC)
  - ○ Outpatient Surgery
  - ○ Psychiatric
- ☐ Mental Health Specialty Services
- ☐ Part B Drugs (>$1,000) (chemo, injectables, etc.)
- ☐ Rehab: Cardiac/Pulmonary
- ☐ Skilled Nursing Facility (non-participating SNF)
- ☐ Transplant
- ☐ Wound Care Management Products (cellular and tissue-based products, etc.)

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 7 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 1-833-215-9332.

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.