AMERICAN HEALTH ADVANTAGE OF IDAHO

Auth. Submission Fax: 833-434-0552

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER AND FOR CERTAIN SERVICES BY PARTICIPATING PROVIDERS. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage.

AUTHORIZATION REQUEST

Member Name ______________________ DOB ______________ **Member ID** ______________________

Nursing Facility ____

Requesting Provider / Type______________________________ NPI/TIN: ______________________

Phone #: ______________________ Fax #: ______________________

Primary Diagnosis ____

Diagnoses (ICD-10 Codes) Related to Auth. Request ______________________________

Servicing Provider/Facility: ______________________________ NPI/TIN: ______________________

Servicing Provider Phone#: ______________________ Servicing Provider Fax#: ______________________

Include all Clinical Documentation with request. NOTE: A delay in submitting all relevant and necessary clinical required to make a medical necessity decision may result in a delay in receiving an authorization determination.

Inpatient Admit **Observation** **Behavioral Health Admit** **SNF (post hospital discharge)** **SIP (Skill in Place)**

Start Date for service checked above ______________________ (this field must be completed)

DME **New Patient - Non-participating Physician Office Visit** **Follow-up - Non-participating Physician Office Visit**

Procedure Code(s)/Quantities:______________________________Scheduled Date for Services______________

Diagnostic Testing or Procedure (List Test or Procedure)______________________________________

Procedure Code(s)______________________________________Scheduled Date for Services______________

THERAPY / HHC

REQUEST FOR PART B THERAPY or HOME HEALTH SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

Request is for **Initial Visits** **Additional visits**

	# Visits Requested	Frequency	Procedure Code(s)	SOC	Evaluation
PT	__________	_____W_____	__________	__________	__________
OT	__________	_____W_____	__________	__________	__________
ST	__________	_____W_____	__________	__________	__________
HHA	__________	_____W_____	__________	__________	______ N/A ______

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

Standard Authorization: Authorization Requests (properly completed and including supporting medical record documentation)are completed within 14 days per the CMS guidelines. Our goal is 5-7 days.

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:______________________________________ Date Completed:______________________

Name of Person Completing this Form (please print name): ______________________________

Notification will be faxed upon determination; please complete the following for notification of the decision.

Who is Receiving Authorization Notification Fax (please print name): ______________________________

Contact phone number: ______________________ Authorization Notification Fax number:______________________

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.