Standardized Prior Authorization Request Form

PLEASE COMPLETE ALL INFORMATION BELOW. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the plan to which you submit your request for claim review.

The Standardized Prior Authorization Form is not intended to replace payer-specific prior authorization procedures, policies and documentation requirements. For payer-specific policies, please reference the payer-specific websites.

Health Plan: HPI	**Health Plan Fax#:** 508-756-1382	**Date Form Completed and Faxed *(required)*:**

Clear Form

Service Type Requiring Authorization [1,2,3] *(check all that apply)*

Ambulatory/Outpatient Services	**Ancillary**	**Dental**	**Durable Medical Equipment**
☐Surgery/Procedure (SDC)	☐Acupuncture	☐Adjunctive Dental Services	☐Prosthetic Device
☐Infusion or Oncology Drugs	☐Chiropractic	☐Endodontics	☐Purchase
	☐IVF / ART	☐Maxillofacial Prosthetics	☐Renal Supplies
	☐Non-Participating Specialist	☐Oral Surgery	☐Rental
		☐Restorative	

Home Health/Hospice	**Inpatient Care/Observation**	**Medication**
☐Home Health *(please indicate:)*	☐Acute Medical/Surgical	Buy or bill or submit via the **Medical** benefit: ☐Yes ☐No
☐SN ☐OT ☐HHA	☐Long-Term Acute Care	Purchase or submit via **Pharmacy** benefit: ☐Yes ☐No
☐PT ☐ST ☐MSW	☐Acute Rehab	Cost per dose is **Greater than $2,000:** ☐Yes ☐No
☐Hospice	☐Skilled Nursing Facility	
☐Infusion Therapy	☐Observation	
☐Respite Care		

Nutrition/Counseling	**Outpatient Therapy**	**Transportation**	**Imaging**
☐Counseling	☐Occupational Therapy	☐Non-Emergent Ground	☐Non-Urgent ☐Urgent/Emergent*
☐Enteral Nutrition	☐Physical Therapy	☐Non-Emergent Air	*Precert required for claim payment, clinical not required. Must submit form within 2 business days of the urgent imaging service.
☐Infant Formula	☐Pulmonary/Cardiac Rehab		
☐Total Parenteral Nutrition	☐Speech Therapy		

Provider Information

***Required field**

***Provider Name/Address:** ☐*Referring Provider* ☐*Treating Provider*	***Tax ID#:**	***Phone#:**	***Fax#:**
***Servicing Facility Name/Address:**	***Tax ID#:**	***Phone#:**	***Fax#:**

***Contact Person:**	***Phone#:**	**Email/Fax#:**

Member Information

***Required field**

***Patient Name:**	***Insurance Plan Member ID#:**	***Gender:** ☐ Male ☐ Female	***Date of Birth:**

Address:	**Phone#:**

If other insurance: **Insurance Company:**	**Policy#:**

Diagnosis/Planned Procedure Information

***Required field**

***Procedure/Service Description:**	***Diagnosis Description:**
CPT/HCPCS Codes:	**ICD-10 Codes:**

Quantity Requested: ☐**Hours** ☐**Days** ☐**Months** ☐**Visits** ☐**Dosage**

***Service Start Date:**	**Surgery Date** *(if applicable)*:	***Service End Date:**

[1] Please attach plan specific templates that are required for supporting clinical documentation.
[2] Not all services listed will be covered by the benefits in a member's health plan product.
[3] This form does not replace payer-specific prior authorization requirements.