AUTHORIZATION SUBMISSION FAX: 888-300-9320

CommuniCare ADVANTAGE

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. Payment 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 # Fax #
Primary Diagnosis (ICD-10 Code & Description:

Section II: Provider Information

Requesting Facility Name:
Requesting Facility Address:
Requesting Facility Phone #: Requesting Facility Fax #:
Requesting Facility NPI: Requesting Facility Tax ID:

Requesting Provider Name:
Requesting Provider Address:
Requesting Provider NPI: Requesting 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

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.