

**Medicare Medical
Prior Authorization Request Form**

COMPLETE ALL SECTIONS OF THIS FORM. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Senior Whole Health		
Fax:	Date Form Completed/Faxed:	
Authorization Type		
<input type="checkbox"/> In-Network <input type="checkbox"/> Out of Network	Urgency: <input type="checkbox"/> Expedited* <input type="checkbox"/> Standard <input type="checkbox"/> Concurrent <input type="checkbox"/> Retrospective * Please request "expedited" when applying the standard timeframe for making the determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.	
Service Type Requiring Authorization (check all that apply)		
Ambulatory/Outpatient Services <input type="checkbox"/> Surgery/Procedure (SDC) <input type="checkbox"/> Infusion or Oncology Drugs	Ancillary <input type="checkbox"/> Acupuncture <input type="checkbox"/> Chiropractic <input type="checkbox"/> IVF/ART <input type="checkbox"/> Non-Participating Specialist	Dental <input type="checkbox"/> Adjunctive Dental Services <input type="checkbox"/> Endodontics <input type="checkbox"/> Maxillofacial Prosthetics <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Restorative
Durable Medical Equipment <input type="checkbox"/> Prosthetic Device <input type="checkbox"/> Purchase <input type="checkbox"/> Renal Supplies <input type="checkbox"/> Rental	Home Health/Hospice <input type="checkbox"/> Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) <input type="checkbox"/> Hospice <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Respite Care	Inpatient Care/Observation <input type="checkbox"/> Acute Medical/Surgical <input type="checkbox"/> Long-term Acute Care <input type="checkbox"/> Acute Rehab <input type="checkbox"/> Observation Skilled Nursing Facility (Select level): <input type="checkbox"/> LTC <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III
Nutrition/Counseling <input type="checkbox"/> Counseling <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Infant Formula <input type="checkbox"/> Total Parental Nutrition	Outpatient Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Pulmonary/Cardiac Rehab <input type="checkbox"/> Speech Therapy	Transportation <input type="checkbox"/> Non-emergent Ground <input type="checkbox"/> Non-emergent Air
Other—please specify:		
Provider Information (*Denotes required field)		
*Requesting Provider Name/NPI#:	*Phone:	Fax:
*Servicing Provider Name/NPI# (and Tax ID if required):	*Phone:	Fax:
<input type="checkbox"/> <i>Same as Requesting Provider</i>		
*Contact Person:	*Phone:	Fax:

Member Information (<i>*Denotes required field</i>)		
*Patient Name:	* <input type="checkbox"/> Male <input type="checkbox"/> Female	*DOB: (MM/DD/YYYY)
*Health Insurance ID#: <i>If other insurance, please specify:</i>		*Patient Account/Control Number:
Address:		Phone:
Diagnosis/Planned Procedure Information (<i>*Denotes required field</i>)		
*Principal Diagnosis Description: ICD-10 Codes:	*Principal Planned Procedure (Description and CPT/HCPCS Code): # of Units Being Requested: <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Visits <input type="checkbox"/> Dosage	
Secondary Diagnosis Description: ICD-10 Codes:	Secondary Planned Procedure (Description and CPT/HCPCS Code): # of Units Being Requested: <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Visits <input type="checkbox"/> Dosage	
*Service Start Date:	*Service End Date:	

****Confidentiality Notice****

WARNING: Unauthorized interception of this telephonic communication could be a violation of Federal and State law. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 CFR, Part 2) and may be protected by state laws regarding confidentiality of patient records. These rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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