REQUEST FOR AUTHORIZATION OF SERVICES FORM

PERENNIAL ADVANTAGE

***Call** UM at: 1-844-788-6959 (TTY 711) for CO or 1-844-788-6986 (TTY 711) for OH (Call Center Hours M-F 8a– 8p)*

***FAX** Form and Clinical to: 1-833-610-2399*

**** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY*

***PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

MEMBER DATA

Member Name _____ **Date of Birth** _____ **Member's Plan ID** _____

Name of Nursing Facility _____ **Referring Provider** _____ Is Referring Provider: ☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request _____

PART A and OUTPATIENT SERVICE

SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)

☐ **Part A SNF (post hospitalization)** **Start Date**_____ **# of Days Requested** _____

☐ **Part A Skill-in-Place** **Start Date**_____ **# of Days Requested** _____

☐ **Additional Part A Days** **Reason:** _____ **# of Days Requested**_____

☐ **Outpatient Diagnostic or Service** **Date of Procedure/Service**_____

CPT Code or Name of Procedure/Service: _____

Provider or Facility Name (REQUIRED): _____

Provider or Facility Contact Number (REQUIRED): _____

PART B / THERAPY

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

☐ **PT** ☐ Initial Visits Start of Care:_____ Plan: ____ days per week for _____ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **PT** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐ N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

☐ **OT** ☐ Initial Visits Start of Care:_____ Plan: ____ days per week for ___ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **OT** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐ N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

☐ **ST** ☐ Initial Visits Start of Care_____ Plan: ____ days per week for _____ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **ST** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

Part B Therapies Require NP Signature

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization Request**

☐ **Expedited Authorization (Must Read and SIGN)**: By signing below I certify that waiting for a decision longer than 72 hours **could place the Member's life, health, or ability to gain maximum function in serious jeopardy**.

Signature for Expedited Review Only: _____

Name of Person Completing this Form:_____ **Date Completed:** _____

Contact #: _____ **Contact FAX:** _____

NP Signature _____