CONCURRENT AUTHORIZATION REQUEST
SNP | SIP | IRF | LTACH

Submit this completed form by fax to **1-833-610-2399,** or on our provider portal:
https://secure.healthx.com/PerennialAdvantage.Provider
Call 1-844-788-6959 (TTY 711) for CO/PA or 1-844-788-6986 (TTY 711) for OH to speak with a representative.

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐ Routine/Standard ☐ Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION	
Member Name:	Member ID:
Date of Birth:	Authorization number:

CURRENT LEVEL OF CARE		
☐ SNF	☐ Inpatient Rehab	☐ LTACH
CM/SW Name:	Phone Number:	Fax Number:
Prior Living Conditions: ☐ Independent	☐ Lives with others	☐ SNF ☐ ALF/ILF
Owned DME: ☐ Cane (SP/Quad) ☐ Walker ☐ Rollator ☐ W/C ☐ Power w/c or Scooter ☐ BSC ☐ Other:		

BRIEF CURRENT MEDICAL STATUS UPDATE	
Provide brief update on member status/diagnosis/medical condition (If there is a decline, please state reason):	
Wound Location, size:	Wound treatment/dressing type and frequency:

IV Antibiotics: please include name/frequency/duration:

Name: _____ Frequency: _____ Duration: _____

Name: _____ Frequency: _____ Duration: _____

Name: _____ Frequency: _____ Duration: _____

PT Updates Bed mobility: Transfers: Ambulation:	OT Updates Feeding: Bathing: Dressing: Toileting:	ST Updates: Language/Expression: Cognition: Diet:

Anticipated Discharge Date:
D/C Barriers:
CLINICAL INFORMATION
• Clinical/ therapy documentation/ assessments should be within 72 hours of request. • Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc. • Missing this information may delay the decision on your request or may result in Lack of Information denial.

Provider Attestation: By signing below, I certify that the patient's medical records accurately reflect the information provided. I understand that Perennial Advantage may request medical records for this patient at any time in order to verify this information. I further understand that if Perennial Advantage determines this information is not reflected in the patient's medical records, Perennial Advantage may request a refund of any payments made and/or any other remedies available.

Please certify the following by signing and dating below:

Provider Signature: _____ Date:_____

Please fax form to: 1-833-610-2399