Pre-Service Authorization Form

Request Date:	Submitted By:	Phone:	Fax:

For items and services, please allow 72 hours for processing urgent requests and 14 days for non-urgent requests. For Part B drugs, please allow 24 hours for processing urgent requests and 72 hours for non-urgent requests.

☐ URGENT REQUEST – I certify that this request is urgent and medically necessary to treat an illness, injury or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

This authorization is valid for 90 days, unless otherwise indicated. Only authorized services may be provided. Clinical documentation is required for authorization processing, please attach all documents. Fax documents: 866-613-0157. For questions, call: 877-364-4566.

Rationale for Out-of-Network Care

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MEMBER INFORMATION			
Member Name:		Plan Member ID:	
Date of Birth:		Phone:	
REQUESTING PROVIDER INFORMATION			
Name:			
Address:			
Phone:	Fax:	NPI#:	
SERVICING PROVIDER INFORMATION	☐ Same as Requesting Provider	☐ In-Network	☐ Out-of-Network
Name:			
Address:			
Phone:	Fax:	NPI#:	
LOCATION/FACILITY OF SPECIALTY SERVICE	☐ In-Network	☐ Out-of-Network	
Place of Treatment: Provider Office ☐	Outpatient Facility ☐	Inpatient Facility ☐	Home ☐ Other ☐
Location/Facility Name:			
Location/Facility Address:			
Phone:	Fax:	NPI#:	

Attestation for Non-Participating Providers (*Required Field): This authorization serves as a one-time out of network agreement at 100% of Medicare allowable for a non-participating provider. This authorization request will be valid for 30 days.

Signature: _____ **Date:** _____

SERVICE REQUEST			
☐ Behavioral Services - IOP	☐ Consult/Office Visit	☐ Home Health	☐ Surgery - Inpatient
☐ Behavioral Services - PHP	☐ Diagnostics Imaging	☐ Infusion Therapy/Injections	☐ Surgery - Outpatient
☐ Card./Pulm. Rehab	☐ Dialysis	☐ Orthotics & Prosthetics	☐ Transplant - Evaluation
☐ Chemotherapy	☐ DME	☐ PT/ST/OT (after eval, circle all that applies)	☐ Other (describe)
Other Relevant Information:			
ICD 10 Code(s):			
CPT/HCPCS Codes with Quantity for Each Code:			
Begin Date:		End Date:	

Please see **Prior Authorization - Medical Services List** for the services that require prior authorization. For the complete list, please visit us online at www.clearspringhealthcare.com. **Disclaimer:** Member must be eligible at the time services are provided. Services must be a covered Health Plan Benefit and medically necessary with prior authorization. An authorization is not guarantee of payment.