

# PRE-SERVICE AUTHORIZATION FORM



Request Date:	Submitted By:	Phone:	Fax:
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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

<input type="checkbox"/> <b>URGENT REQUEST</b> – 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.
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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 –

### MEMBER INFORMATION

Member Name:	Plan Member ID:
Date of Birth:	Phone:

### REQUESTING PROVIDER INFORMATION

Name:		
Address:		
Phone:	Fax:	NPI#

### SERVICING PROVIDER INFORMATION

<input type="checkbox"/> Same as Requesting Provider	<input type="checkbox"/> In-Network	<input type="checkbox"/> Out-of-Network
Name:		
Address:		
Phone:	Fax:	NPI#

### LOCATION/FACILITY OF SPECIALTY SERVICE

<input type="checkbox"/> In-Network	<input type="checkbox"/> Out-of-Network
<b>Place of Treatment:</b>	<input type="checkbox"/> Provider Office <input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Inpatient Facility <input type="checkbox"/> Home <input type="checkbox"/> 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 90% of Medicare allowable for a non-participating provider. This authorization request will be valid for 30 days.

<b>Signature:</b>	<b>Date:</b>
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### SERVICE REQUEST

<input type="checkbox"/> Behavioral Services - IOP	<input type="checkbox"/> Consult/Office Visit	<input type="checkbox"/> Home Health	<input type="checkbox"/> Surgery - Inpatient
<input type="checkbox"/> Behavioral Services - PHP	<input type="checkbox"/> Diagnostics Imaging	<input type="checkbox"/> Infusion Therapy/Injections	<input type="checkbox"/> Surgery - Outpatient
<input type="checkbox"/> Card./Pulm. Rehab	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Orthotics & Prosthetics	<input type="checkbox"/> Transplant - Evaluation
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> DME	<input type="checkbox"/> PT/ST/OT (after eval, circle all that applies)	<input type="checkbox"/> 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](http://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.