

Begin Date:

## **Pre-Service Authorization Form**

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.    WEMBER INFORMATION	Request Date:	Submitted By:		Phone:		Fax:		
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.  Internationale for Out-of-Network Care    MEMBER INFORMATION	Troquest 2 ato.	oceans.						
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.    Authorization is required for authorization processing, please attach all documents. Fax documents: 866-613-0157. For questions, call: 877-364-4566.   Authorization is required for authorization processing, please attach all documents. Fax documents: 866-613-0157. For questions, call: 877-364-4566.					or non-urger	nt requests. For	Part B drugs, please	
documentation is required for authorization processing, please attach all documents. Fax documents: 866-613-0157. For questions, call: 877-364-4566.  lationale for Out-of-Network Care    MEMBER INFORMATION								
MEMBER INFORMATION  Member Name:	documentation is required	l for authorization						
Plan Member Name:   Plan Member ID:	Rationale for Out-of-Network	k Care						
Plan Member Name:   Plan Member ID:								
Date of Birth:    REQUESTING PROVIDER INFORMATION		Plan Mombor ID:	Plan Mambar ID:					
REQUESTING PROVIDER INFORMATION  Name:  Address:    Fax:	Member Name.	Plan Weimber ib.	Flatt Welliber ID.					
Name:	Date of Birth:	Phone:	Phone:					
Name:	REQUESTING PROVIDER INFO	RMATION						
Phone:								
Same as Requesting Provider   In-Network   Out-of-Network   Name:    Address:	Address:							
Name: Address:  Phone:   Fax:	Phone:	hone: Fax: NPI#:						
Address: Phone:   Fax:	SERVICING PROVIDER INFORM	MATION	Same as Requesting Pro	vider	In-Network		Out-of-Network	
Phone:	Name:							
In-Network   Out-of-Network   Out-of-Network   Place of Treatment:   Provider Office   Outpatient   Inpatient Facility   Home   Other   Inpatient Facility   Home   Inpatient Facility   Home   Inpatient   Inpatient Facility   Home   Inpatient   Inpatient			1					
Place of Treatment:								
Facility   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:   Date:				_		= 1 =		
Date:	Place of Treatment: Provide	der Office 🔲		npatient Facility	Home	Ш	Other	
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:	Location/Facility Name:		· · · · · ·		l.			
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:								
Medicare allowable for a non-participating provider. This authorization request will be valid for 30 days.    Signature:	Phone:	NPI#:						
SERVICE REQUEST  Behavioral Services - IOP	-	_	-			of network agree	ement at 100% of	
□ 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:	Signature:			Date:				
□ 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:	SERVICE REQUEST							
□ Card./Pulm. Rehab       □ Dialysis       □ Orthotics & Prosthetics       □ Transplant - Evaluation         □ Chemotherapy       □ DME       □ PT/ST/OT (after eval, circle all that applies)       □ Other (describe)         Other Relevant Information:	☐ Behavioral Services - IOP	☐ Consult/	Office Visit	☐ Home Health		Surgery - Inpatient		
☐ Chemotherapy ☐ DME ☐ PT/ST/OT (after eval, circle all that applies) ☐ Other (describe) ☐ Other Relevant Information:	☐ Behavioral Services - PHP	☐ Diagnos	tics Imaging	Infusion Therapy/Injections		☐ Surgery - Outpatient		
Other Relevant Information:  ICD 10 Code(s):	☐ Card./Pulm. Rehab	☐ Dialysis		Orthotics & Prosthetics		☐ Transplant - Evaluation		
ICD 10 Code(s):	Chemotherapy	☐ DME				Other (describe)		
	Other Relevant Information:							
CPT/HCPCS Codes with Quantity for Each Code:	ICD 10 Code(s):							
	CPT/HCPCS Codes with Quant	tity for Each Code	::					

Please see **Prior Authorization - Medical Services List** for the services that require prior authorization. For the complete list, please visit us online at <a href="www.clearspringhealthcare.com">www.clearspringhealthcare.com</a>. **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.

End Date: