Prominence Health Plan

MEDICARE PRIOR AUTHORIZATION REQUEST FORM

All REQUIRE MEDICAL RECORDS TO BE ATTACHED

Phone: 855-969-5884 Fax: 813-513-7304

FOR BEHAVIORAL HEALTH CALL 844-540-9595

This form is for prior authorization requests which will be processed as quickly as possible depending on the member's health condition.
Do not write STAT, ASAP, Immediate, etc. on this form. Please complete appropriate sections below.

Complete remainder of form for ALL requests.

Member Information

Name:_____ Date of Birth: _____Plan ID#:_____

Requesting Provider Information

Requesting provider name: _____ TIN#: _____

Phone: (____)_____ Fax: (____)_____ Contact Person:_____ Ext._____

Please provide a short clinical statement to support your request:

Facility Requested (No Abbreviations)	**Provider Requested** (No Abbreviations)
Name: _____	Name: _____
TIN#: _____ □Non-Par	TIN#: _____ □Non-Par
Phone: (_____)_____ Fax: (_____)_____	Phone: (_____)_____ Fax: (_____)_____

Date of Service:	**Diagnosis:**	**ICD-10 Code(s):**
	Diagnosis:	**ICD-10 Code(s):**

Service Requested: Check appropriate request(s)

- ☐ Abortions
- ☐ Acute Rehabilitation Facility
- ☐ Ambulance (for non-emergency transport)
- ☐ Behavioral Health
  - ☐ Inpatient
  - ☐ Outpatient and Partial Hospital Program
  - ☐ Neurological Testing
  - ☐ Psychological Testing
- ☐ Chemotherapy
- ☐ Chiropractic & Acupuncture (after 12 visits)
- ☐ Clinical Trials (not approved by Medicare)
- ☐ Cosmetic Procedures
- ☐ Dental Services (Medicare covered)
- ☐ Dialysis
- ☐ DME/Orthotics/Prosthetics > $500 (see*below)
- ☐ Enteral Feedings
- ☐ Experimental/Investigational Procedures
- ☐ Genetic Testing/Blood Products
- ☐ Home Health Services
- ☐ Hospice *Notification Only*
- ☐ Hyperbaric Oxygen Therapy
- ☐ Implantable Pump/Device or Stimulator
- ☐ Injectables/Infusion Therapy
- ☐ Injections > $100 billed charges per unit
- ☐ Inpatient Hospital
- ☐ Medical Nutrition Education
- ☐ MOHS Procedure (Dermatology)
- ☐ Non-Participating Provider
- ☐ Obstetrical Care
- ☐ Outpatient Hospital (excludes Labs, Ultrasounds & X-rays)
- ☐ Pain Management
- ☐ Radiation Therapy/Radiation Oncology
- ☐ Radiology/Diagnostic Test: CT, CTA, Echo, MRA, MRI, Nuclear Med. Cardiac, PET, Pill, MUGA, Medical Oncology, Virtual Colonoscopy or Endoscopy and3-D Ultrasounds
- ☐ Rehab: Cardiac/Pulmonary/Respiratory
- ☐ Rehab Therapy: PT, OT, SP – Outpatient Hospital & Office Visits (after 12 visits)
- ☐ Skilled Nursing Facility
- ☐ Sleep Studies
- ☐ Sterilizations
- ☐ TMJ Joint Treatment
- ☐ Transplant
- ☐ Wound Care (Outpatient Hospital Only)

CPT or HCPC Code(s)	Description	# of Visits/Injections

Check box in this section for expedited requests ONLY. Medicare's definition of expedited is defined as one where "applying the standard time for making a determination could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function." ☐ **Yes**

*DME > $500 if purchased or > $38.50 per month if rented. Includes all wheelchairs, hospital beds, CPAPs, BiPAPs, nerve and bone growth stimulation devices and oxygen, as well as TENS devices, wound care/wound vacuums and related supplies, repairs, miscellaneous codes, and all Medicare non-covered items