AMERICAN HEALTH ADVANTAGE OF FLORIDA

Auth. Submission Fax: 866-381-1194

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER AND FOR CERTAIN SERVICES BY PARTICIPATING PROVIDERS. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage.

AUTHORIZATION REQUEST

Member Name _____ DOB _____ **Member ID** _____

Nursing Facility _____

Requesting Provider / Type_____ NPI/TIN: _____

Phone #: _____ Fax #: _____

Primary Diagnosis _____

Diagnoses (ICD-10 Codes) Related to Auth. Request _____

Servicing Provider/Facility: _____ NPI/TIN: _____

Servicing Provider Phone#: _____ Servicing Provider Fax#: _____

Include all Clinical Documentation with request. NOTE: A delay in submitting all relevant and necessary clinical required to make a medical necessity decision may result in a delay in receiving an authorization determination.

☐ **Inpatient Admit** ☐ **Observation** ☐ **Behavioral Health Admit** ☐ **SNF (post hospital discharge)** ☐ **SIP (Skill in Place)**

Start Date for service checked above _____ (this field must be completed)

☐ **DME** ☐ **New Patient - Non-participating Physician Office Visit** ☐ **Follow-up - Non-participating Physician Office Visit**

Procedure Code(s)/Quantities:_____Scheduled Date for Services_____

☐ **Diagnostic Testing or Procedure** (List Test or Procedure)_____

Procedure Code(s)_____Scheduled Date for Services_____

THERAPY / HHC

REQUEST FOR PART B THERAPY or HOME HEALTH SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

Request is for ☐**Initial Visits** ☐**Additional visits**

	# Visits Requested	Frequency	Procedure Code(s)	SOC	Evaluation
PT	_____	_____W_____	_____	_____	_____
OT	_____	_____W_____	_____	_____	_____
ST	_____	_____W_____	_____	_____	_____
HHA	_____	_____W_____	_____	_____	_____ N/A _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** Authorization Requests (properly completed and including supporting medical record documentation)are completed within 14 days per the CMS guidelines. Our goal is 5-7 days.

☐ **Expedited Authorization (Must Read and Sign):** By signing below I certify that waiting for a decision under the standard time frame could place the Member's life, or health in serious jeopardy.

SIGNATURE:_____ Date Completed:_____

Name of Person Completing this Form (please print name): _____

Notification will be faxed upon determination; please complete the following for notification of the decision.

Who is Receiving Authorization Notification Fax (please print name): _____

Contact phone number: _____ Authorization Notification Fax number:_____

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.