AGERIGHT ADVANTAGE

REQUEST FOR AUTHORIZATION OF SERVICES FORM

***Call** UM at 844-854-6885 opt 3 (Call Center Hours M-F 8a– 5p)* ***FAX** Form and Clinical to 800-503-6095*

****** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY***

***PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

MEMBER DATA

______________________ ______________________ ______________________

Member Name **Date of Birth** **Member's Plan ID**

______________________ ______________________ Is Referring Provider: ☐ Plan NP

Name of Nursing Facility **Referring Provider** ☐ PCP ☐ Plan PA ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request ______________________

PART A and OUTPATIENT SERVICE

SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)

☐ **Part A SNF (post hospitalization)** **Start Date**__________ **# of Days Requested** __________

☐ **Part A Skill-in-Place** **Start Date**__________ **# of Days Requested** __________

☐ **Additional Part A Days** **Reason:** ______________________ **# of Days Requested**_____

☐ **Outpatient Diagnostic or Service** **Date of Procedure/Service**______________________

CPT Code or Name of Procedure/Service: ______________________

Provider or Facility Name (REQUIRED): ______________________

Provider or Facility Contact Number (REQUIRED): ______________________

PART B / THERAPY

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

☐ **PT** ☐ Initial Visits Date of Eval_____________ Plan: ____ days per week for _____ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **PT** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐ N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

☐ **OT** ☐ Initial Visits Date of Eval_______________ Plan: ____ days per week for ___ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **OT** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐ N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

☐ **ST** ☐ Initial Visits Date of Eval_____________ Plan: ____ days per week for _____ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **ST** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization Request**

☐ **Expedited Authorization (Must Read and SIGN)**: By signing below I certify that waiting for a decision longer than 72 hours **could place the Member's life, health, or ability to gain maximum function in serious jeopardy**.

Signature for Expedited Review Only: ______________________

Name of Person Completing this Form:______________________ **Date Completed:** ______________________

(Please Print Name)

Contact #: ______________________ **Contact FAX:** ______________________

12/10/2018