AmeriHealth Caritas Next

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# Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
All fields must be completed for the request to be processed.
Please make a selection where applicable throughout the document.

| | |
|---|---|
| DATE | |
| TYPE OF REQUEST | _____ URGENT _____ STANDARD _____ RETROSPECTIVE |
| TREATMENT SETTING | _____ INPATIENT _____ OUTPATIENT |
| REQUEST TYPE | _____ EXTENSION _____ INITIAL _____ CANCEL _____ CHANGES DOS/SETTING |
| | _____ ADDITIONAL CLINICAL _____ DISCHARGE PLANNING _____ OTHER |
| PREVIOUS AUTHORIZATION NUMBER | |
| CONTACT NAME | |
| CONTACT PHONE | CONTACT FAX |

## MEMBER INFORMATION

| | | |
|---|---|---|
| LAST NAME | | |
| FIRST NAME | | |
| MEMBER ID | | |
| MEMBER PHONE NUMBER | DATE OF BIRTH | |
| MEMBER STREET ADDRESS | | |
| CITY | STATE | ZIP |

## PROVIDER INFORMATION

| | | | |
|---|---|---|---|
| PROVIDER NAME | | | |
| PROVIDER TIN | PROVIDER NPI | | |
| PROVIDER PHONE NUMBER | PROVIDER FAX NUMBER | | |
| PROVIDER STREET ADDRESS | | | |
| CITY | | STATE | ZIP |
| PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING | | | |
| FACILITY NAME | | | |
| FACILITY TIN | FACILITY NPI | | |
| FACILITY PHONE NUMBER | FACILITY FAX NUMBER | | |
| FACILITY STREET ADDRESS | | | |
| CITY | | STATE | ZIP |
| PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING | | | |

| | | | |
|---|---|---|---|
| REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE) | | | |
| REFERRING PHYSICIAN TIN | | | |
| REFERRING PHYSICIAN NPI | | | |
| REFERRING PHYSICIAN PHONE NUMBER | | | |
| REFERRING PHYSICIAN FAX NUMBER | | | |
| REFERRING PHYSICIAN STREET ADDRESS | | | |
| CITY | | STATE | ZIP |
| PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING | | | |

## MEDICAL SECTION

| DIAGNOSIS CODE | | |
|---|---|---|
| | | |

| PROCEDURE CODE | START DATE | END DATE | NUMBER OF UNITS | CODE DESCRIPTION |
|---|---|---|---|---|
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## MEDICAL SECTION

NOTES

PLEASE FAX TO **1-844-412-7890**

PROVIDERS ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION FOR SERVICES PRIOR TO SCHEDULING. PLEASE SUBMIT CLINICAL INFORMATION, AS NEEDED, TO SUPPORT MEDICAL NECESSITY OF THE REQUEST. REQUESTS WILL NOT BE PROCESSED IF MISSING CLINICAL INFORMATION OR CPT AND ICD-10 CODES. AS A REMINDER, AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT; PAYMENT IS SUBJECT TO BENEFIT COVERAGE RULES, INCLUDING MEMBER ELIGIBILITY AND ANY CONTRACTUAL LIMITATIONS IN EFFECT AT THE TIME OF SERVICE.

**URGENT MEDICAL CONDITION:** ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.

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