Prior Authorization Request Form

To submit requests, please fax completed form to the Utilization Review Department: 202-905-0157.
If you have any questions, you can reach the Utilization Review Department directly:202-821-1132.

Providers are responsible to obtain prior authorization for services prior to scheduling. Please submit clinical information as needed to support medical necessity of the request. Prior authorization payment is subject to request meeting medical necessity

Requests may not be processed if clinical information or CPT and ICD-10 codes are missing. 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. Please select urgent only when the member's life or health may be seriously jeopardized. Doing so will help us to respond to your request accurately and with greater efficiency.

Today's Date:_____Requested Date of Service:_____

REQUEST TYPE

○	**Urgent Preservice**	**Decisions will be made within 24 hours of receipt; I certify that applying the standard review time frame may seriously jeopardize the life or health of the member. (Member has an appointment or requires service within 24 hours, today, or is in the office now.)**
○	**Urgent Expedited Pre-service**	**Decisions will be made within 72 hours of receipt of the request. (Member will need services within 72 hours.)**
○	**Standard Non-Urgent Preservice**	**Decisions will be made no later than 14 calendar days of receipt of request. (Member will need services within the next 14-days or more). *Most requests fall in this category. ***
○	**Post-Service**	**Decisions will be made no later than 14 calendar days of receipt of request. (Member received services already, authorization was not given, and a claim was not submitted or denied.)**

Physician's Signature:_____Date signed:_____

MEMBER INFORMATION

Alliance/Medicaid ID Number:	Enrollee Last Name:	Enrollee First Name:

Date of Birth: *I* Gender: ○ Male ○ Female

Additional Insurance carrier ○ Yes ○ No Insurance Carrier Name: _____

REVIEW TYPE

○ Initial	○ *Change DOS/Setting	○ *Extension of Services	○ Additional Clinical
○ Cancel	○ *Other *(specify)*	○ Discharge Planning (Services needed for member discharged from inpatient setting such as hospital, skilled nursing facility, subacute facility, etc.)	

*Please Specify *(If applicable, previous authorization number)*_____

SERVICE TYPE:

○ Orthotics/ Prosthetic ○ Home Care ○ Non-Par ○ Durable Medical Equipment (DME) ○ *Other

*Please Specify *(If applicable, previous authorization number)*_____

PROVIDER INFORMATION

Submitting Provider Name:	Contact Name and Phone Number:	Fax Number:
Services Provided by or Facility/Provider ID#	Contact Name and Phone Number:	Fax Number:

TREATMENT SETTING:

○ Outpatient ○ Inpatient ○ Home ○ In-Office ○* Other

*Please specify if other selected: _____

DO NOT WRITE BELOW THIS LINE: FIELDS TO BE COMPLETED BY TRUSTED HP

Authorization #_____ Date of Service Coverage Period _____

(Revised February 7, 2018)

Prior Authorization Request Form

Member ID#: _____

HCPCS/CPT CODES				
ICD-10 Code	HCPCS/CPT	Code Description	Dates of Service	
			From	Thru
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I

Other Clinical Information- Include/attach clinical/office notes, labs, imaging reports, etc.to support medical necessity.
If this is an out-of-network request, please provide an explanation.

Number of Visits Being Requested: _____

REHABILITATION SERVICES

Typeof Therapy: ○ Speech ○ Physical ○ Occupational ○ *Other

Number of Units/Visits Requested:	Previous Authorization Number:	*Date(s)* Requested:
○ Extension	○ Initial	

Additional Comments:

TRUSTED Health Plan
1100 New Jersey Avenue, S.E.,
Suite 840, Washington, DC 20003

Utilization Management Contact Information
Phone: 202-821- 1132
Fax: 202-905-0157

Prior Authorization Request Form

Member ID#:_____

HOME CARE

Name of Agency	Number of Units/ Visits Requested:	Number of Previous Visits:
Previous Authorization Number:	○ Initial	○ Extension

Additional Comments:

DURABLE MEDICAL EQUIPMENT

Diagnostic Indication:	Duration and Frequency of Use:	Acute or Chronic condition:
Previous Authorization Number:	Length of time needed:	
○ Initial	○ Renewal	
○ Rental	○ Purchase	

Additional Comments:

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