Hometown Health Senior Care Plus

MEDICAL PRIOR AUTHORIZATION

Submission Instructions

Use this form to request authorization by fax or mail if the member's plan requires prior authorization for medical healthcare services, including mental health and substance abuse. PLEASE NOTE THAT AN EXPEDITED REQUEST MUST MEET THE FOLLOWING CRITERIA: **An expedited request is one that by applying the standard time frame for making a determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.**

To ensure that your request is processed timely, please fax your request to only one of the fax numbers below based on the member's benefit plan and service requested. The benefit plan is available on the front of the member's identification card.

FAX REQUESTS FOR MEDICAL PRIOR AUTHORIZATION FOR ALL PLANS TO: 775-982-3744

IF THIS REQUEST IS FOR A MEDICATION, please ensure which benefit (Medical or Pharmacy) is responsible for coverage.

- Medications covered under the Medical Benefit are administered in an office by a health care provider (NOT self-administered such as intravenous, intrathecal, intraarticular, intramuscular).
- Medications covered under the Pharmacy Benefit are medications that are typically filled at retail pharmacies and can be self-administered (such as capsules, tablets, topical creams/patches, subcutaneous injections).

ADDITIONAL INFORMATION AND INSTRUCTIONS:

For any questions, contact Customer Service at **775-982-3232** or **800-336-0123**.

Mail / Attention: **Healthcare Utilization Management**
Hometown Health • 10315 Professional Cir. • Reno, NV 89521

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See the previous page for submission instructions.

Date _____

SECTION 1 General Information

REVIEW TYPE ☐ **Standard** ☐ **Expedited** Clinical Reason for Expedited _____

An expedited request is one that by applying the standard time for making a determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

SECTION 2 Member Receiving Services

Name _____ Phone _____ Date of Birth _____

☐ Male ☐ Female ☐ Other ☐ Unknown Member ID Number _____ Plan _____

Street Address _____ City _____ State _____ Zip _____

SECTION 3 Provider Information

REQUESTING PROVIDER/GROUP

Name _____

Specialty _____

Street Address _____

City _____ State _____ Zip _____

NPI Number _____

Tax ID Number _____

Phone _____ Fax _____

Contact Name _____ Phone _____

SERVICING PROVIDER OR FACILITY

Name _____

Specialty _____

Street Address _____

City _____ State _____ Zip _____

NPI Number _____

Tax ID Number _____

Phone _____ Fax _____

Contact Name _____ Phone _____

SECTION 4 Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD 10 Code)

Requested Service or Procedure	Code	Start Date	End Date	Diagnosis Description	Code

☐ Inpatient ☐ Outpatient Surgery ☐ Observation ☐ Specialist Office Visit (Number of Visits) _____ ☐ Other _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse ☐ Home Health ☐ DME

SECTION 5 Additional Information