

PHONE: 844-873-2905

FAX: 844-873-3163

**PRIOR AUTHORIZATION REQUEST  
Custodial Care Benefits Only**

**\*\*\*Form must filled out completely and clinical information attached\*\*\***

Submitted by: <input type="checkbox"/> Agency	Today's Date: / /
Person to contact for this Submission:	Phone:

<b>Patient's Name:</b>	<b>DOB:</b>	<b>Member ID:</b>
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<b>Requesting Provider Section:</b> <small>(i.e. Provider name not location or facility)</small>	<b>Servicing Provider Section:</b> <small>(i.e. Facility or Provider Name, May be the same as Requesting Provider)</small>
Requesting Provider Name:	Custodial Care Agency:
NPI:	NPI:
Tax ID:	Tax ID:
Address:	Address:
Fax:	Fax:
Phone:	Phone:

Date of Admission:	Date of Discharge:
Name of Facility:	

Start of Care Date:	<p>Authorization requests must be submitted within 7 days of the start of care. Retro requests beyond 7 days will be denied. Custodial care hours must be used within 90 days of start of care date.</p>
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ICD-10 Code	Diagnosis	ICD-10 Code	Diagnosis
1.		3.	
2.		4.	

	CPT Code	Description	Units/Quantity
X	99509	Custodial Care 1 unit = 15 minutes	20 Hours/80 units

Please document what the custodial care hours will be used for:

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This request will be processed per the standard organization determination timeframes. If this request needs to be treated as "expedited", please note clinical justification why applying the standard timeframe for a determination could seriously **jeopardize the member's life, health or ability to regain maximum function**:

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to [www.healthteamadvantage.com](http://www.healthteamadvantage.com) for specific codes requiring a prior authorization.

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