PHONE: 844-806-8217 Opt 3 FAX: 844-873-3163

Acute, SNF, LTACH, IRF Authorization Request

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

Patient's Current Location (If Facility, name of Facility is Required):

❑ER:_____ ❑Acute:_____ ❑LTAC/Rehab:__

❑Office_____ ❑Home_____ ❑Other:_____

Today's Date:				
Request for:	❑IP Acute	❑SNF	❑LTACH	❑IP Rehab

Patient's Name:	**DOB**	**Member ID:**
Requestor Name:		Phone:
Expected Admit Date:	Bed Level:	

Ordering Physician Information	**Facility Information**
Physician Name:	Facility Name:
Phone:	Phone:
Fax:	Fax:
NPI:	NPI:
Tax ID:	Tax ID:
Address:	Address:

ICD-10 CM Diagnosis Description	**ICD-10 CM Code**

Describe any special circumstances which should be considered when authorizing services:

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 for specific codes requiring a prior authorization.