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:_____

☐ Select this box if the member is new to HTA and these services were previously authorized by another health plan.

| 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.htanc.com for specific codes requiring a prior authorization.