Request for Prior Authorization

SUPERIOR HealthPlan

Date of request * ___ / ___ / ____

*Required items. Please write only in designated areas.

Member Information

Member ID*

Last Name

Date of Birth* / /

First Name

Provider to Perform the Service

NPI*

Fax Number*

TPI*

Contact Number*

Taxonomy

Contact Name / Requestor

Tax ID*

Last Name, First Initial or Facility Name

Submitting / Referring Provider

'X' in box if same as above.

Fax Number*

NPI*

Contact Number*

Last Name, First Initial or Facility Name

Contact Name / Requestor

Requested Service

Type of Service*:

- DME rental
- DME purchase *(requires signed physician's order)*
- Home Health *(Require signed physician's order and plan of care/treatment plan)*
- Office Visit
- Outpatient Services
- Rehab *(Require signed physician's order and plan of care/treatment plan)*
- Inpatient
- Other _____

LTSS Services:

- PAS
- DAHS
- ERS
- Home delivered meals
- Med Box Refills
- Other _____

Place of Service*:

- Office
- Outpatient Hospital/ASC
- Home
- Outpatient Clinic
- Outpatient Rehab
- Inpatient
- Other _____

Clinical Review

Procedure codes:

Procedure code/CPT,HCPCS* modifier

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Procedure code/CPT,HCPCS* modifier

Service Description:

Diagnosis:

Referring Diagnosis Code*

Referring Diagnosis Code

'X' indicates clinicals or plan of care attached.

/ / **Start Date***

/ / **End Date***

Units/Visits* X **Day** / **Week** / **Month**

Contact Information

Fax Numbers:

LTSS Bexar:	866-224-8254
LTSS Nueces:	866-703-0903
Admissions	888-886-0170
Referrals:	800-690-7030
Hotline:	800-218-7508

Urgent Request - By checking this box, I certify that this is an urgent request for medically necessary treatment, which must be treated within 24 hours.

_____

Signature of Requesting Physician (required)

Superior requires that certain services be approved before the service is rendered. Please refer to the SHP website, www.superiorhealthplan.com for the most current full listing of authorized procedures and services. Note that an authorization is not a guarantee of payment and is subject to utilization management review, benefits and eligibility.

For office use only

Authorization number: _____

Units: _____

Dates authorized: _____