ATTENTION:
Use Updated Prior Authorization (PA) Fax Form

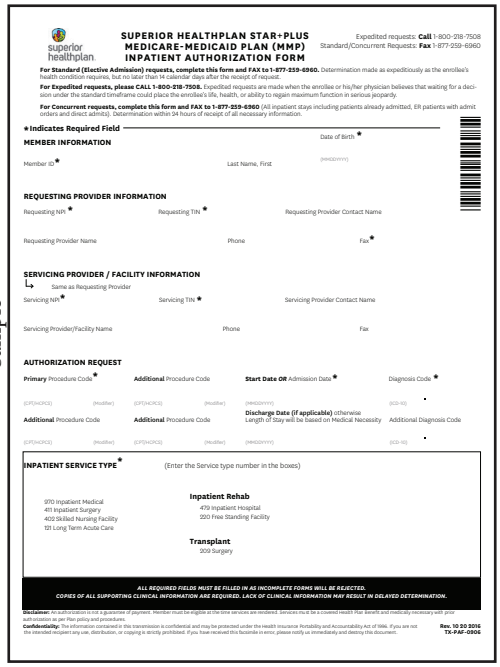
We are processing your request, please use the updated forms for future requests.

This will allow:

- -FASTER processing
- -EASIER to fill out
- -SAVABLE - New forms can be filled out electronically and SAVED with information.

To Fax Authorizations:

1. Download the PA Fax forms directly from SuperiorHealthPlan.com
2. Open and fill in requested fields
3. Print and FAX



Sample

superior healthplan

SUPERIOR HEALTHPLAN STAR+PLUS MEDICARE-MEDICAID PLAN (MMP) INPATIENT AUTHORIZATION FORM

Expedited requests: **Call** 1-800-218-7508
Standard/Concurrent Requests: **Fax** 1-877-259-6960

For Standard (Elective Admission) requests, complete this form and FAX to 1-877-259-6960. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests, please CALL 1-800-218-7508. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Concurrent requests, complete this form and FAX to 1-877-259-6960 (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 24 hours of receipt of all necessary information.

***Indicates Required Field**

MEMBER INFORMATION

Member ID* | Last Name, First | Date of Birth* (MM/DD/YYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI* | Requesting TIN* | Requesting Provider Contact Name

Requesting Provider Name | Phone | Fax*

SERVICING PROVIDER / FACILITY INFORMATION

↳ Same as Requesting Provider

Servicing NPI* | Servicing TIN* | Servicing Provider Contact Name

Servicing Provider/Facility Name | Phone | Fax

AUTHORIZATION REQUEST

Primary Procedure Code* (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | **Start Date OR** Admission Date* (MM/DD/YYYY) | Diagnosis Code* (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | **Discharge Date (if applicable)** otherwise Length of Stay will be based on Medical Necessity (MM/DD/YYYY) | Additional Diagnosis Code (ICD-10)

INPATIENT SERVICE TYPE* (Enter the Service type number in the boxes)

970 Inpatient Medical
411 Inpatient Surgery
402 Skilled Nursing Facility
131 Long Term Acute Care

Inpatient Rehab
479 Inpatient Hospital
220 Free Standing Facility

Transplant
209 Surgery

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior auth occasion as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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TX-PAF-0906

Prior Authorization requests can be submitted through the Secure Provider Portal for faster confirmation and response.

SuperiorHealthPlan.com

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