REQUEST FOR PRIOR AUTHORIZATION

Date of Request* ____________ *Required fields ☐ Continuity of Care

☐ **Urgent Request** - By checking this box, I certify that this is an urgent request medically necessary treatment, which must be treated within 24 hours.
Please Note: Urgent is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to require medical treatment evaluation or treatment within 24 hours to prevent serious deterioration of the member's condition or health.

Member Information

First Name ____________ Member ID* ____________
Last Name ____________ Date of Birth* ____________

Servicing Provider Information

NPI* ________ TPI* ________ Contact Number* ____________
Tax ID* ____________ Fax Number* ____________
Last Name, First Initial or Facility Name ____________
Contact Name / Requestor ____________

Referring Provider (eg. PCP or Specialist) or Facility Information

☐ Check box if same as above.

NPI* ________ TPI* ________ Contact Number* ____________
Tax ID* ____________ Fax Number* ____________
Last Name, First Initial or Facility Name ____________
Contact Name / Requestor ____________

Requested Service

Type of Service

☐ DME Rental* ☐ DME Purchase* ☐ DME Incontinence Supply*
☐ Home Health ☐ SNV ☐ PDN ☐ Therapy ☐ PPECC
☐ Genetic Testing Type: ____________ Pregnant ☐ Yes ☐ No
☐ Outpatient Services ☐ Office Visit ☐ Rehab ☐ Evaluations
☐ Re-Evaluations ☐ Non-Emergent Transportation ☐ Inpatient
☐ Other ____________

*All DME require signed physician orders. All HH and Rehab requests require signed physician's order and plan of care/treatment plan.

Place of Service*

☐ Office
☐ Outpatient Hospital / ASC Gen
☐ Home
☐ Outpatient Clinic
☐ Outpatient Rehab
☐ Inpatient
☐ Other ____________

LTSS Services

☐ Personal Attendant Services
☐ Day Activity & Health Services
☐ Personal Care Services
☐ Nursing Services
☐ Home Delivered Meals
☐ Other ____________

☐ Assisted Living
☐ Adult Foster Care
☐ Adaptive Aids
☐ Emergency Response Services
☐ Minor Home Modifications

☐ Transition Assistance Services
☐ Employment Assistance
☐ Supported Employment
☐ Respite Services
☐ Flexible Family Support Services

Clinical Review

☐ Check box to indicate clinicals or plan of care.

Procedure Codes

Procedure code / CPT, HCPCS* modifier ____________
Procedure code / CPT, HCPCS modifier ____________
Procedure code / CPT, HCPCS modifier ____________

Diagnosis

Referring Diagnosis code* ____________
Referring Diagnosis code ____________

Service Description

Start Date* ____________
End Date* ____________
Units / Visits* ____ X DD ____ Wk ____ MM ____

Contact Information

Fax Numbers:

STAR Kids/STAR Health LTSS.................. 1-877-644-4561
STAR+PLUS LTSS.................................. 1-866-895-7856
Admissions.. 1-888-886-0170
Referrals 1-800-690-7030
Hotline 1-800-218-7508
Outpaitent CHIP Requests Only 1-844-310-5517
Discharge Planning............................... 1-844-495-2361

Signature of Requesting Physician

Superior requires services be approved before the service is rendered. Please refer to 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** ____________