REQUEST FOR PRIOR AUTHORIZATION

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

superior healthplan

☐ **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 LTSS	1-877-644-4561
STAR Health LTSS	1-800-690-7030
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** _____