URGENT DC PLANNING - REQUEST FOR PRIOR AUTHORIZATION

superior healthplan™

Date of Request* ☐☐ / ☐☐ / ☐☐☐☐

*Required items. Please write only in designated areas.

Member Information

Member ID*

Date of Birth* ☐☐ / ☐☐ / ☐☐☐☐

First Name

Last Name

Provider to Perform the Service

NPI*

TPI*

Tax ID*

Last Name, First Initial or Facility Name

Contact Number*

Fax Number*

Contact Name / Requestor

Submitting / Referring / Performing Provider

☐ 'X' in box if same as above.

NPI*

Tax ID*

Last Name, First Initial or Facility Name

Contact Number*

Fax Number*

Contact Name / Requestor

Requested Service

Type of Service

☐ DME Rental* ☐ DME Purchase* ☐ DME Incontinence Supply*

☐ Home Health ☐ SNV ☐ PDN ☐ Therapy

☐ Genetic Testing Type:__________ Pregnant ☐ Yes ☐ No

☐ Outpatient Services ☐ Office Visit

☐ Rehab ☐ Evaluations ☐ Re-Evaluations

☐ Non-Emergent Transportation

☐ Inpatient

☐ Other ________________

LTSS Services

☐ PAS

☐ DAHS

☐ ERS

☐ Home Delivered Meals

☐ Med Box Refills

☐ Other ______________

Place of Service*

☐ Office

☐ Outpatient Hospital / ASC Gen

☐ Home

☐ Outpatient Clinic

☐ Outpatient Rehab

☐ Inpatient

☐ Other_____________

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

Clinical Review

Procedure Codes

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Diagnosis

Referring Diagnosis Code*

Referring Diagnosis Code

☐ 'X' indicates clinicals or plan of care

Service Description URGENT DISCHARGE PLANNING

☐☐ / ☐☐ / ☐☐☐☐ Start date*

☐☐ / ☐☐ / ☐☐☐☐ End date*

Units / Visits* X ☐ Day ☐ Week ☐ Month

Contact Information

Fax Numbers:

LTSS Bexar:	1-866-224-8254
LTSS Nueces:	1-866-703-0903
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

☐ 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.

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Signature of Requesting Physician *(required)*

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

URGENT DISCHARGE PLANNING

Authorization Number: ______________

Units: ______________

Dates Authorized: ______________