PRIOR AUTHORIZATION REQUEST FORM

<u>Please read all instructions</u> prior to completing this form.

Do not use this form:

1.) To request an appeal.
2.) To confirm eligibility.
3.) To verify coverage.
4.) To ask whether a service requires prior authorization.
5.) To request prior authorization of a prescription drug.

Addition information and instructions:

<u>Section IV</u>

- If the *Request Provider* or *Facility* will also be the *Service Provider* or *Facility*, enter "Same".
- If the patient's plan requires them to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same".

<u>Section VI</u>

- Attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.), if needed.

Prior Authorization Request Form
Section I --- Submission

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Requestor Name	Phone	Fax

Section II --- General Information

Review Type: ☐ Non-Urgent ☐ Urgent ☐ Yes ☐ No If urgent, I attest the clinical supports urgency.	Request Type: ☐ Initial Request ☐ Concurrent

Section III --- Patient Information

Name	Patient Contact Phone	DOB	Sex: ☐ Male ☐ Female ☐ Non-Binary
Subscriber Name (if different)		Member ID#	Group #

Section IV --- Provider Information

Requesting Provider or Facility			*Service Provider or Facility*		
Name			Name		
NPI#	TIN#	Specialty	NPI#	TIN#	Specialty
Phone	Fax		Phone	Fax	
Contact Name and Phone			Name of Primary Care Provider (see instructions)		
			Phone	Fax	

Section V --- Services Requested (with CPT or HCPCS Code) and Supporting Diagnoses (with ICD10 Code)

Planned Service or Procedure	Code	Unit	Start Date	End Date	Diagnosis Description (ICD10 Version___), if available

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Other (specify)_____

Inpatient Level of Care:
☐ SNF ☐ LTAC ☐ Medical Rehab ☐ MH ☐ CD ☐ Residential ☐ Inpatient

Outpatient Level of Care:
☐ Physical Therapy ☐ Occupation Therapy ☐ Speech Therapy ☐ Mental Health/Substance Abuse ☐ IOP
Number of sessions_____ Duration_____ Frequency_____ Other_____

Home Health Care:
☐ Nursing ☐ PT ☐ ST ☐ OT ☐ SNV ☐ HHA ☐ SW ☐ Infusion
Number of visits requested_____ Duration_____ Frequency_____ Other_____

DME: (MD signed ordered attached? ☐ Yes ☐ No)
Equipment/Supplies_____
HCPCS Codes_____ Duration_____

Section VI --- Clinical Documentation (See Instructions Page, Section VI)

If more information is needed, Luminare Health Benefits, Inc. may call the requesting provider or authorized representative directly at: _____.