COMMUNITY Health Options®

Notification/Prior Approval Form

Prior Approval requests should be submitted through the provider portal at Provider.HealthOptions.org. For urgent Prior Approval requests, call (855) 542-0880. If you are unable to submit a Prior Approval request through the portal, please send via fax at (877) 314-5693.

Member Information * Denotes required field	
*Member Name	*Date of Birth
*Health Insurance ID #	Other Health Insurance (Please specify)
Phone	Address

☐ **Routine** – Routine pre-service requests will generally be processed within 72 hours or two business days, whichever is earliest, upon receipt of all medically necessary information.

☐ **Urgent** - Urgent Pre-Service requests will generally be processed within one calendar day of receipt of all necessary information. Urgent requests are based on clinical presentations that could seriously jeopardize the Member's life or health, ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment. To initiate urgent referrals by phone 24/7 call (855) 542-0880.

Emergency services (911 ambulance transport and ED evaluation/treatment) do not require Prior Approval.

Provider Information	
***Requesting/Ordering Provider**	***Servicing/Rendering Provider or Facility**
*Name	*Name
*Address	*Address
*Phone	*Phone
*Fax	*Fax
*Contact Person	*Specialty
*Contact Phone	*NPI
*NPI	Please list additional provider information, if applicable, to include name, NPI & location.
Clinical Summary or clinical notes must be attached. Incomplete information may delay the decision process.	

Procedure Information

Requires submission of written clinical information with request

Ambulatory/Outpatient Procedure - Requests must be submitted within 10 business days of the date of service

☐ **Non-Emergent Ambulance Air Transport**
Prior approval is recommended; however, requests must be submitted within 10 business days of the date of service.

☐ **Colonoscopy**

If preventive: ☐Initial ☐Routine follow-up Date of last colonoscopy: _____

☐ **Home Health**
Requests must be submitted within 10 business days from the date of service
Check all that apply:
☐SN ☐PT ☐OT ☐ST ☐HHA ☐SW
☐MD ☐NP ☐PA

☐ **Hospice**

☐ **Outpatient procedure/surgery**

Service: _____

See separate PA forms:

- Behavioral Health Services
- Medical Benefit Drugs

Admissions

Medical necessity review applies to the entire stay unless otherwise specified

Acute Care: Admission
Notification is required within 48 hours (or by noon the first business day following a weekend/holiday admission even if already discharged)

This applies to scheduled, elective admissions, and admissions from the Emergency Department (ED).

☐ **Acute Care: Inpatient Admission**
Admissions from the ED are subject to clinical Review of the entire stay to determination stabilization and support discharge coordination.

See separate PA form:

- Behavioral Health Services

ARF and SNF In-network Admissions
Medical necessity review is waived for bed days before notification if notification is completed within 3 business days of admission.

Acute Rehabilitation Facility (ARF)

☐ In-network: Notification required within three business days
☐ Out-of-network: Must obtain Prior Approval

Long-Term Acute Care Hospital (LTACH)

☐ Must obtain Prior Approval. All admissions. Medical necessity review applies to entire stay.

Skilled Nursing Facility (SNF):

☐ In-network: Notification required within three business days
☐ Out-of-network: Must obtain Prior Approval. Medical necessity review applies to entire stay.

Diagnosis Information
*ICD10 (List codes and description):
1.
2.
3.
4.
5.
6.

Planned Procedure Information		
CPT/HCPCS Code	Description - list primary procedure first	# of units or visits within 90 days
1.		
2.		
3.		
4.		
5.		
6.		
*Date(s) of service/planned procedure/admission (Preservice approvals are limited to 90 days) Start: End:		

Durable Medical Equipment/Medical Supplies
The plan provides for the least expensive equipment necessary to meet the medical needs

***Type of Request**

- ☐ Rental (Quantity is requested in months, typically limited to 3 months)
- ☐ Purchase (submit CPAP/BIPAP compliance report for CPAP/BIPAP purchase request)
- ☐ Replacement (include date of initial purchase and product serial number)

For additional information regarding the requirements for DME please find our DME guide here

Item Code	Item Description	Quantity Requested	Billed Price Per Unit	Total Billed Amount	"X" confirms least expensive option to meet needs (required)
*Date(s) of service of rental/date of purchase: Start: End:					

Out-of-Network Services: Please advise Member to call Member Services at (855) 624-6463 to inquire about coverage.