Community HEALTH OPTIONS®

Notification/Prior Approval Form Page 1

Fax completed form to Medical Management to (877) 314-5693

Member Information (*Denotes Required Field)		
*Patient Name:	*☐ Male *☐ Female	*DOB:
*Health Insurance ID#:	Other Health Insurance (please specify):	
Address:	Phone:	

☐ **Routine** ▸ Routine Pre-Service requests are generally processed within two business days of receipt of all necessary information.

☐ **Urgent** ▸ Urgent Pre-Service requests are processed within two calendar days. Urgent requests are based on clinical presentations that could seriously jeopardize the Member's life or health, ability to regain maximum function, or subjects 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/OrderingProvider:**	***Servicing/Rendering Provider or Facility:**
*Name:	*Name:
*Address:	*Address:
*Tel:	*Tel:
*Fax:	*Fax:
*Contact Person:	*Specialty:
*Contact Tel:	*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 decision process.

Requested Service(s) Requiring Notification (Check All That Apply)	
In-Network Home Health** ☐ Home Health (Please Check): ☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ Social Work Notification is required within 48 hours of the first home visit. Please refer to the online Quick Reference Guide: Health Options Medical Notification and Prior Approval Requirements for further details.	**In Network Observation within 24 hours** ☐ In Network Observation concurrent review > 24 hours (Admit or Discharge at 48 hours) **In Network Inpatient within 48 hours** ☐ Acute Medical/Surgical (Note: inpatient admit must pass midnight) ☐ Acute Rehab Facility** ☐ Skilled Nursing Facility** **Clinical must be submitted within three (3) business days of admission with concurrent review commencing on day seven (7).

Diagnosis Information (*Denotes Required Field)	
*ICD10 (List codes AND description):	
1.	3.
2.	4.

continued

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Notification/Prior Approval Form Page 2

Planned Procedure Information (*Denotes Required Field)

*Procedure/Service requested (list all CPT/HCPC Codes AND Description required)

☐ **Outpatient procedure/surgery**

☐ **Transportation (Air/Ground/Water)**
Transport coverage is limited to the nearest medical facility licensed and capable of providing the medically necessary level of care.

☐ **Hospice**

☐ **Applied Behavioral Analysis (ABA Services)**
All other Behavioral Health authorizations go through BHCP.
BHCP Fax: (207) 761-3079 • Phone: (855) 481-7047; Option 3

☐ **Inpatient procedure/surgery**
Notification by facility is required within 48 hours of admission.

☐ **Medications-medical benefit (e.G., Injection, infusion, oral chemo)**
Medications: number of units = number of doses requested.

☐ **Neuropsychological testing (suspected medical origin)**

☐ **Out-of-network (OON) services**
For all OON Services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage.

CPT/HCPCS Code	Description	# of units or visits	CPT/HCPCS Code	Description	# of units or visits
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

*Date(s) of service/ planned procedure/admission:

Start: End:

Durable Medical Equipment/Medical Supplies (*Denotes Required Field)
The Plan Provides For The Least Expensive Equipment Necessary To Meet The Medical Needs

*Type of Request
☐ Rental (Quantity is requested in months)
☐ Purchase (submit CPAP/BIPAP compliance report for CPAP/BIPAP purchase request
☐ Replacement (include date of initial purchase & product serial number)

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:

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