Prior-Authorization/Referral Request Form

This standard form may be utilized to submit a prior authorization request to CNS Healthcare for review along with the necessary clinical documentation to support the request. The form does not support Behavioral Health, Pharmacy Services or other services. For more info, please contact us. The standardized prior authorization form is intended to be used to submit prior authorizations requests by fax (or mail).

The *Prior Authorization Request Form* is for use with the following service types:

Services	Definition (includes but is not limited to the following examples)
Ambulatory/Outpatient Services	Medical services provided to a member in an outpatient setting: hospital outpatient departments, hospital licensed health centers, or other hospital satellite clinics; physicians' offices; nurse practitioners' offices; freestanding ambulatory surgery centers; day treatment centers; members' home.
Durable Medical Equipment (DME)	Equipment used to fulfill a medical purpose and enable mobility. Can be rented or purchased and can include wheelchairs, walkers, canes, med/surg supplies, renal supplies and prosthetic devices.
Home Health	Home health: home health aide; physical; occupational; speech therapy; respite care; infusion therapy.
Inpatient Care/Observation	Inpatient services are medical services provided to a member admitted to an acute inpatient hospital, including long term acute care, acute rehab, and skilled nursing facility. This category also includes medical observation.
Outpatient Therapy	Occupational, physical, pulmonary or cardiac, and speech therapy services, including diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, rehabilitate, or prevent worsening functions that affect daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.
Transportation	Non-emergent ground and non-emergent air models of transportation, including ambulance.
Provider Information	The requesting provider is the physician and the servicing provider can be the same physician as the requesting provider or the facility where the service will be provided. The contact person is the person who is filling out the form.
Diagnosis/Planned Procedure Information	Examples of services that align with # of units being requested: • Hours: Home health aide • Days: Home health; physical therapy • Months: DME • Visits: Outpatient therapies; home health (RN, PT, OT) • Dosage: Different measurements (mg, g, etc.) that can be used for infusion
Other Information	• Any supporting clinical documentation should be submitted in addition to this form for prior authorization approval. • For services not listed, please refer to plan specific medical policies for prior authorization requirements. • Some services may require physician signature and should be submitted with the supporting clinical documentation.

The form is currently ***not*** intended to: capture supporting clinical documentation, support Behavioral Health, Pharmacy Services or other services.

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COMPLETE ALL INFORMATION. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Health Plan: HealthChoice of Michigan	**Health Plan Fax #:** (248) 994-4669	***Date Form Completed and Faxed:**

Service Type Requiring Authorization[1, 2, 3] *(Check all that apply)*

Request Type:	**Ambulatory/Outpatient Services**	**Ancillary**	**Durable Medical Equipment**
☐ PRIOR-AUTHORIZATION ☐ REFERRAL **Credentialed with CNS Healthcare?** ☐ YES ☐ NO	☐ Surgery/Procedure (SDC) ☐ Infusion or Oncology Drugs	☐ Diagnostic ☐ Therapeutic ☐ Custodial Specify:	☐ Prosthetic Device ☐ Purchase ☐ Renal Supplies ☐ Rental
Home Health/Hospice	**Inpatient Care/Observation**	**Outpatient Therapy**	**Radiology/Imaging**
☐ Home Health (Please circle: ☐ SN, PT, OT, ST, HHA, MSW) ☐ Infusion Therapy ☐ Respite Care ☐ Other:	☐ Acute Medical/Surgical ☐ Acute Rehab ☐ Skilled Nursing Facility ☐ Observation	☐ Occupational Therapy ☐ Physical Therapy ☐ Pulmonary/Cardiac ☐ Rehab ☐ Speech Therapy	☐ CT/CAT ☐ MRI/MRA ☐ X-ray Ultrasound
Transportation ☐ Non-emergent Ground ☐ Non-Emergent Air	**Other—please specify:**		

Provider Information (**Denotes required field*)

***Requesting Provider Name and NPI#:**	***Phone:**	***Fax:**
***Servicing Provider Name, Address, and NPI#:** ***Specialty:** *Same as Requesting Provider*	***Phone:**	***Fax:**
***Servicing Facility Name and NPI#:** *Same as Requesting Provider*	***Phone:**	***Fax:**
***Contact Person:**	***Phone:**	**Fax:**

Member Information (**Denotes required field*)

***Patient Name:**	* **Male** ☐ **Female** ☐	***DOB:**
Health Insurance ID#:** ***If other insurance, please specify:	***Patient Account/Control Number:**	
Address:	**Phone:**	

Diagnosis/Planned Procedure Information (**Denotes required field*)

***Principal Diagnosis Description:** **ICD-10 Codes: and DX**	***Principal Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** Hours Days Months Visits Dosage

Secondary Diagnosis Description: **ICD-10 Codes:**	**Secondary Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** Hours Days Months Visits Dosage
***Service Start Date:**	***Service End Date:**
Notice of Authorization (Internal Office Use Only)	
Date Reviewed: **Status:** ☐ **Approved** ☐ **Denied** **Authorization #** **Signature:**	**CPT codes included in AUTH:**

[1] Please attach plan specific supporting clinical documentation.
[2] Not all services listed will be covered by the benefits in a member's health plan product.
[3] This form does not replace additional specific prior authorization requirements.