

**Request for Services Requiring Prior Authorization**  
**Fax 1-800-283-2117**  
**Telephone number 1-877-915-0551 Option 2**

**\*\*MEDICARE ONLY\*\***  
Please Fax ALL Requests for  
**DME/HH/INFUSION**  
Services Directly to  
**844-215-4265**

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| <p>Member Name: _____</p> <p>Plan Name (Circle One) : Simply** Better Clear Health</p> <p>Health Plan ID #: _____</p> <p>Member DOB: ____/____/____ Phone: (____) _____ - _____</p> <p>PCP Name: _____</p> <p>PCP ID #: _____ Phone: (____) _____ - _____</p> <p>Referring Physician Name: _____</p> <p>Contact Person: _____</p> <p>Referring Physician Telephone: (____) _____</p> <p>Referring Physician Fax Number: (____) _____</p> | <p>Referred to: _____</p> <p>Specialty : _____</p> <p>Referred to : Provider ID #: _____</p> <p>Referred to Fax #: (____) _____</p> <p>Diagnosis (ICD-): _____, _____, _____, _____</p> <p>CPT Codes: _____, _____, _____, _____</p> <p>Reason for Referral: _____</p> <p>_____</p> <p>_____</p> |
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**Request Type:**     Standard     Expedited/Urgent\* By checking this box I certify that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to regain maximum function. You may call our Pre-Certification department and advise the request is Expedited/Urgent at 1-877-915-0551, option 2

**IMPORTANT NOTE:** *An Expedited/Urgent request for a determination is a request in which waiting for a decision under the Standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.*

**Is this request related to an accident?**     YES     NO                      **Does this member have other insurance coverage?**     YES     NO

MVA     LONG TERM CARE MANAGED CARE     Worker's Compensation                       Medicaid     Other

INSURANCE (specify): \_\_\_\_\_

**The following services require PRE-AUTHORIZATION--Please submit supporting clinical documentation to determine medical necessity, TO INCLUDE RECENT OFFICE VISITS, DIAGNOSIS CODES AND ANY PERTINENT RECENT X-RAY OR LAB REPORTS.**

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| <p><b>Inpatient Services:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hospital Admissions</li> <li><input type="checkbox"/> Birthing Centers</li> <li><input type="checkbox"/> Observation</li> </ul> <p><b>Outpatient Surgical Services:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hospital</li> <li><input type="checkbox"/> Ambulatory Surgical Center</li> </ul> <p><b>Outpatient Services Performed at a Hospital:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Colonoscopy</li> <li><input type="checkbox"/> Endoscopy</li> <li><input type="checkbox"/> Wound Care</li> <li><input type="checkbox"/> Hyperbaric Oxygen Treatment</li> <li><input type="checkbox"/> All Therapy and Rehabilitative Services</li> <li><input type="checkbox"/> Any other Hospital Services</li> </ul> | <p><b>Outpatient Services:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> PET Scan</li> <li><input type="checkbox"/> MRI</li> <li><input type="checkbox"/> Sleep Study</li> <li><input type="checkbox"/> Total OB Care</li> <li><input type="checkbox"/> SPEECH, OCCUPATIONAL OR RESPIRATORY Therapies (ST/OT/RT):</li> <li><input type="checkbox"/> Chemotherapy</li> <li><input type="checkbox"/> Radiation Therapy</li> <li><input type="checkbox"/> <b>Medicaid</b> Durable Medical Equipment (DME), Home Health, AND Infusion Services</li> </ul> |
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**\*\*Medicare ONLY\*\***  
**\*\*Please fax ALL requests for Durable Medical Equipment (DME), HOME HEALTH (HH), AND INFUSION SERVICES DIRECTLY TO 844-215-4265**

**\*\*\*PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT\*\*\***

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