Medical Prior Authorization

Submission Instructions

Use this form to request authorization by fax or mail if the member's plan requires prior authorization for medical health care services. *Please note that an expedited request must meet the following criteria:* ***An expedited request is one that by applying the standard time frame for making a determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.***

To ensure that your request is processed timely, please fax your request to only one of the fax numbers below based on the member's benefit plan and service requested. The benefit plan is available on the front of the member's identification card.

Fax Requests for Medical Prior Authorization for **All Plans** to: **775-982-3744**

Fax Requests for **Mental Health & Substance Abuse** for the following plans to **775-551-7000**

- Hometown Health Plan
- Hometown Health Providers
- Hometown Health Individual & Family Plan
- Senior Care Plus

If this request is for a medication, please ensure which benefit (Medical or Pharmacy) is responsible for coverage.

- Medications covered under the Medical Benefit are administered in an office by a health care provider (NOT self-administered such as intravenous, intrathecal, intra-articular, intramuscular).
- Medications covered under the Pharmacy Benefit are medications that are typically filled at retail pharmacies and can be self-administered (such as capsules, tablets, topical creams/patches, subcutaneous injections).

Additional Information and Instructions:

For any questions, contact Customer Service at **775-982-3232** or **1-800-336-0123**.

Hometown Health Senior Care Plus

A Medicare Advantage Plan from Hometown Health.

Medical Prior Authorization

See page one for submission instructions.

Date: ____/____/_____

Section 1 General Information

Review Type: ☐ **Standard** ☐ **Expedited** Clinical Reason for Expedited: _____

An expedited request is one that by applying the standard time for making a determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Section 2 Member Receiving Services

Name	Phone	DOB / /	☐ Male ☐ Female ☐ Other ☐ Unknown
Street Address City State Zip		Member ID Number	Plan

Section 3 Provider Information

Requesting Provider/Group			
Name		Specialty	
Street Address City State Zip			
NPI Number	Tax ID Number		
Phone	Fax		
Contact Name	Phone		

Servicing Provider or Facility			
Name		Specialty	
Street Address City State Zip			
NPI Number	Tax ID Number		
Phone	Fax		

Section 4 Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD 10 Code)

Requested Service or Procedure	Code	Start Date	End Date	Diagnosis Description	Code

☐ Inpatient ☐ Outpatient Surgery ☐ Observation ☐ Ambulatory ☐ Specialist Office Visit (Number of Visits) _____ ☐ Other _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions _____ Duration _____ Frequency _____ Other _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits _____ Duration _____ Frequency _____ Other _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No)

Section 5 Additional Information