GEORGIA HEALTH ADVANTAGE

Auth. Submission Fax: 844-917-0644

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage

AUTHORIZATION REQUEST

Member Name _____ DOB _____ Member ID _____

Nursing Facility _____

Requesting Provider / Type_____ NPI: _____

Phone #: _____ Fax #: _____

Primary Diagnosis _____

Diagnoses (ICD-10 Codes) Related to Auth Request _____

Servicing Provider/Facility: _____ Tax ID #: _____

Servicing Provider Phone#: _____ Servicing Provider Fax#: _____

Include all Clinical Documentation with request. NOTE: A delay in submitting all relevant and necessary clinical required to make a medical necessity decision may result in a delay in receiving an authorization determination.

☐ SNF (After Discharge) ☐ Inpatient Admit ☐ Behavioral Health ☐ Outpatient Services ☐ SIP (Skill in Place)

Start Date for above service checked _____ (this field must be completed)

☐ Home Health DME: Rental ☐ or Purchase ☐ (indicate one). Office Visit: ☐ New Patient ☐ Follow/up

☐ Diagnostic Testing or Procedure (List Type and CPT code) _____

Provider/Facility: _____ Scheduled Date for Services (if Scheduled) _____

CPT Codes & Quantities:_____

_____

THERAPY REQUEST

REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

Request for ☐ PT ☐ OT ☐ ST ☐ Other _____

Start Date of Services: _____ Date of Initial Evaluation: _____ Date of Last Exam: _____

Request is for ☐ Initial Visits ☐ Additional visits

# of PT Therapy: _____ _____ Times per Week For _____ weeks

# of OT Therapy: _____ _____ Times per Week For _____ weeks

# of ST Therapy: _____ _____ Times per Week For _____ weeks

List of CPT Codes _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** Authorization Requests (properly completed and includes supporting medical record documentation, when required) from a PCP or Plan NP are completed within 14 days per the CMS guidelines. Our goal is 5-7 days

☐ **Expedited Authorization (Must Read and SIGN):** By signing below I certify that waiting for a decision under the standard time frame could place the Member's life, or health in serious jeopardy.

SIGNATURE: _____ Date Completed:_____

Name of Person Completing this form: _____

Notification will be faxed upon determination. Please complete the following for notification of decision.

Who is Receiving Authorization Notification FAX: _____

Contact#: _____ Authorization Notification FAX:_____

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.