



Prior Authorization Request Form

Fax Requests to 1-833-263-4869

Patient Name: _____

Member ID: _____

Patient's Date of Birth: ____/____/____

Patient's Phone: _____

Expedited

Read Definition below prior to checking box

Check expedited **ONLY** if it meets the definition of expedited request per CMS Guideline 50 - **Expedited Organization** Determination: Enrollee/Physician believes that waiting for a decision under the standard time frame (14 days) could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

IDN Review

Please select service(s) for which you are requesting prior authorization.

Home Health Care

BRAC gene testing

Integrated Oncology/Radiation Therapy

Power Operated Vehicles (CMN required)

Durable Medical Equipment (DME)

Inpatient Rehabilitation/Long Term Acute Care Admit

Part B Therapy

Part B Drugs/Chemotherapy Drugs

Transplant Evaluation or Transplant

Hyperbaric Oxygen

Other: _____

Elective Procedure: please select expected bed type below

Inpatient

Observation

Outpatient

Requesting Provider's Name: _____

Provider's Phone: _____ Provider's Fax: _____

Name of Person Completing Request: _____ Contact Phone: _____

Servicing Facility (if applicable): _____

Facility NPI: _____ Facility TIN: _____

Servicing Provider: _____

Provider NPI: _____ Provider TIN: _____

Provider's Phone: _____ Provider's Fax: _____

Start Date _____ **Frequency** _____

Applicable Diagnoses & ICD-10 Codes: _____

Service Description and Code(s): _____

Medical Rationale for Request: _____

OUT-OF-NETWORK CARE for HMO Members (does not apply for PPO members): Out-of-network care is only considered when services are not accessible in-network.

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call Trinity Health Plan Of New England's Medical Management Department at **1-800-240-3870**.