Prior Authorization Request Form

Trinity Health Plan
Of New England

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.