HEALTH TRADITION

Oncology Pre-Authorization/Prior Authorization Request Form

Complete all Sections to ensure timely review

**All preauthorization requests must be submitted with supporting clinical documentation that is relevant to the request.*

Forms will be returned if not filled out accordingly or if they are submitted without the required clinical information.
Fax to 608.467.5431

Decisions on preauthorization requests submitted with all necessary clinical information will be made within 15 calendar days of receipt of the request.
It is highly recommended you not schedule services prior to receiving an approved authorization

Provider appeals submitted on this form will not be considered.
Please use the claim resubmission request form found on our website.

Section A: Request Information

Today's Date: _____ Schedule Date: _____

☐ Inpatient Admission: ☐ New Diagnosis ☐ Concurrent Review

☐ Urgent: Please explain the medical necessity (see ERISA definitions below) for why this would be urgent outside of scheduling purposes:

_____

ERISA Guidelines state urgent is defined as:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or
2. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care of treatment that is the subject of the claim".

☐ Retro Review *(Retro refers to services already rendered and denied as member liability. Review decisions are made within 30 days of receipt of the request)*

Section B: Type of Request (*check appropriate box)*

☐ Medical/Surgical ☐ DME (include cost of item) ☐ Genetic Testing ☐ Treatment Plan

☐ Home Health ☐ Advanced Imaging ☐ Radiation Therapy

Section C: Member Information: **ALL INFORMATION REQUIRED**

Member Last Name: _____ Member First Name: _____ M. I. _____

Subscriber Number: _____ Date of Birth: _____

Member Phone Number: _____

Section D: Service Information: **ALL INFORMATION REQUIRED**

Description of Service: _____

Procedure Code (CPT/HCPCS): _____

ICD 10: _____ Diagnosis and Stage: _____

J Codes for all drugs: _____

Service Start Date: _____ Service Frequency: _____

Section E: Facility where services will be rendered and Servicing Provider Information: **ALL INFORMATION REQUIRED**

Facility Name: _____ Servicing Provider: _____

Location: _____ Location: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Facility NPI: _____ Provider NPI _____

Completed by: _____

***NOTE:** A release of information form included in the application for insurance was signed by our member.*

Please note that the preauthorization of any procedure does not guarantee benefits or payment. Approval is based on medical necessity as defined in the patient's benefit plan or certificate. All benefits are subject to the term, conditions and exclusions of the benefit plan or certificate. This may include policy language regarding pre-existing conditions or signed affidavits stating that the insurance bears no responsibility, as signed by the insured. Policy exclusions for certain types of services may also apply. For additional benefit information, please contact Health Tradition at 844.825.9319.