HEALTH TRADITION

Health Tradition Pre-Authorization for Behavioral Health

Complete all Sections to ensure timely review

Supporting clinical documentation is required with all requests with initial provider assessment

Urgent Fax to (608) 467-4964

Within 24 hours of initial admission or change in level of care

Provider appeals submitted on this form will not be considered. Please refer to the claim resubmission request form (CL6001-0217)

SECTION A: REQUEST INFORMATION

Today's Date: ______________________________

☐ Prospective ☐ Retro Review

For non-urgent preservice decisions, the organization makes decisions within 15 calendar days, upon receipt of the request with clinical documentation.

☐ Urgent Request *(only if applicable)* Reason for Urgency: ______________________

For urgent preservice decisions, the organization makes decisions within 72 hours, upon receipt of the request with clinical documentation.

According to ERISA, urgent is defined as "any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: *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".*

SECTION B: TYPE OF REQUEST (*CHECK APPROPRIATE BOX)*

☐ Inpatient Acute Care

☐ New Admission

☐ Partial Hospitalization Program (PHP)

☐ Intensive Outpatient Program (IOP)

☐ Behavioral Health Day Treatment

☐ Inpatient Detoxification

☐ Concurrent Review

☐ Residential Treatment ______________________

☐ Discharge Notes

☐ Other ______________________________________

SECTION C: MEMBER INFORMATION

Member Last Name: ________________________ Member First Name: ______________________ M. I. ___

Subscriber Number: ________________________ Date of Birth: ____________________________

Member Phone #: ___________________________

SECTION D: SERVICE INFORMATION

Description of Service: ____

Diagnosis Code: __________________________ Procedure Code (CPT/HCPCS): ____________________

Service Start Date: ________________________ Service Frequency: _______________________________

SECTION E: FACILITY AND SERVICING PROVIDER INFORMATION

Facility Name: ______________________________

Location:

____

NPI (Required): _____________________________

Phone: ______________________________________

Fax: ____

Servicing Provider: ___________________________

Location: ____________________________________

Completed by: ________________________________

Phone: ______________________________________

Fax: ____

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 1-844-825-9319.