HEALTH TRADITION

Health Tradition Pre-Authorization/Prior Authorization Request Form

Complete all Sections to ensure timely review

If service(s) are related to Cancer, Specialty Medications or Behavioral Health please use the designated form

***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 608.781.9654 or for Urgent Services fax to 608.467.4964

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: _____ Completed by:_____

Decisions on preauthorization requests submitted with all necessary clinical information will be made within 15 calendar days of receipt of the request.

☐ Service is Scheduled *(only if applicable)* Schedule Date: _____

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

Decisions on urgent requests submitted with all necessary clinical information will be made within 72 hours of receipt of the request. Urgent requests should not be selected to accommodate a schedule date less than 15 days out unless it meets ERISA guidelines, which state the following:

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".*

☐ Retro Request *(Decisions for retro requests, which refers to services already rendered and denied as member liability, take up to 30 calendar days)*

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

Inpatient Admission: ☐ New Admission ☐ Concurrent Admission ☐ Skilled Nursing ☐ Inpatient Rehabilitation

Outpatient Service:

☐ Whole Body Imaging ☐ Advanced Imaging of Neck and Spine, MRA, and PET

☐ Breast Procedures ☐ Cardiac Nuclear Medicine ☐ Cochlear Implant ☐ Dialysis

☐ Gastric Neurostimulator ☐ Genetic Testing ☐ Vein Surgery ☐ TMJ/Oral Splints/Oral Surgery

☐ Home Health Services ☐ Invasive Spine Procedures ☐ Blepharoplasty/Ptosis Repair ☐ Wound Therapy

☐ Orthopedic Procedures ☐ In Lab Sleep Study ☐ TENS Neurostimulator ☐ Other

☐ DME (include cost of item): _____

☐ Will Neuromonitoring be used during this surgery? If so, by what provider:_____

Section C: Member Information ALL INFORMATION REQUIRED

Member Last Name: _____ First Name: _____ Date of Birth _____

Subscriber #: _____ Phone: _____

Section D: Service Information ALL INFORMATION REQUIRED (If related to Cancer or Behavioral Health use the designated form)

Description of Service: _____

Procedure Code (CPT/HCPCS): _____ Diagnosis Code: _____

Service Start Date: _____Units:_____ Service Frequency: _____

Section E: Facility and Servicing Provider Information ALL INFORMATION REQUIRED

Facility Name: _____

Location: _____

Facility NPI (Required): _____

Phone: _____

Fax: _____

Servicing Provider: _____

Location: _____

Provider NPI (Required): _____

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 844.825.9319.