US FAMILY HEALTH PLAN

Medical Necessity Review/Prior Authorization Form

Fax: 866-337-8690

****PLEASE PRINT****

Request Date:_____**Requestor's**

Name: _____

Phone #: (☐☐☐)☐☐☐-☐☐☐☐

Fax#: (☐☐☐)☐☐☐-☐☐☐☐

Requesting Provider: _____

Requesting Provider NPI: _____

Review Type: ☐ Admission/Initial ☐ Inpatient ☐ Retrospective ☐ Outpatient

Pre-determination completed ☐ Yes ☐ No

If yes: ☐ Approved ☐ Denied Date:

Out of Network request: ☐ Yes ☐ No

REQUEST DETAILS

Place of Service:

☐ Home ☐ Inpatient ☐ Outpatient

☐ Physician Office

Type of Service:

☐ Physical Health ☐ Mental Health ☐ OT/PT

Severity:

☐ Standard (non-urgent) ☐ Expedited/Urgent

By checking the urgent box, you attest that applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function or subject the member to severe pain that cannot be adequately managed.

Other _____

MEMBER INFORMATION

Member Name: _____
(Last, First, Middle)

Address: _____

_____

_____

Date of Birth: ☐☐ / ☐☐ / ☐☐

Member ID #: ☐☐☐☐☐☐☐☐☐☐-☐☐

Phone#: (☐☐☐)☐☐☐-☐☐☐☐

Sex: ☐ Male ☐ Female ☐ Unknown

Age: ☐☐☐

FACILITY INFORMATION

Facility:_____

Address:_____

Phone #: (☐☐☐)☐☐☐-☐☐☐☐

Fax#: (☐☐☐)☐☐☐-☐☐☐☐

TIN #: ☐☐☐☐☐☐☐☐☐

NPI #: ☐☐☐☐☐☐☐☐☐☐

(Required)

Out of Network: ☐ Yes ☐ No

PROCEDURE/SERVICE

Primary Diagnosis: _____

Primary Diagnosis Code: _____

Secondary Diagnosis: _____

Secondary Diagnosis Code: _____

Service/Procedure Code: _____

Description: _____

Start Date: ☐☐ / ☐☐ / ☐☐

End Date: ☐☐ / ☐☐ / ☐☐

Units: _____

☐ Days ☐ Units ☐ Visits (check one)

****PLEASE PRINT****

SERVICING PROVIDER (e.g. DME or Home Health)	**ADMITTING/SERVICING PHYSICIAN**
Name:_____ Address:_____ Phone #: (☐☐☐)☐☐☐-☐☐☐☐ Fax # : (☐☐☐)☐☐☐-☐☐☐☐ TIN #: ☐☐☐☐☐☐☐☐☐ NPI #: ☐☐☐☐☐☐☐☐☐☐ **(Required)** **Out of Network:** ☐ Yes ☐ No	Name: Last, First, Middle _____ Specialty:_____ Address:_____ Phone #: (☐☐☐)☐☐☐-☐☐☐☐ Fax # : (☐☐☐)☐☐☐-☐☐☐☐ TIN #: ☐☐☐☐☐☐☐☐☐ NPI #: ☐☐☐☐☐☐☐☐☐☐ **(Required)** **Out of Network:** ☐ Yes ☐ No

Notes: Please list additional CPT codes, prior treatment history, current treatment plan and other pertinent information in this area.

SUPPORTING DOCUMENTATION

Only submit clinical information that supports the request for service(s) to determine medical and/or psychological necessity or specifically requested.

Type of Review Request	Documentation
All Types of Review Requests	Documentation not included in the review request form that supports the medical or psychological necessity of the requested services.
Urgent Review Requests	Requests can only be submitted as urgent ***if applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function or subject the member to severe pain that cannot be adequately managed.***

Disclaimer Statement

Toney Healthcare Consulting certification determination is based on the information provided herein and is not a guarantee of payment or coverage. Benefits are subject to eligibility and limitations at the time of service. Final payment and coverage determinations shall be made in accordance with the terms, conditions, limitations and exclusions as set forth under the US Family Health Plan policy.

Requesting Provider Attestation Statement

I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical and/or mental health services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering)physician or mental health provider.

Printed Name: _____

Signature: _____

Date: _____

UR/Pre-Authorization Contact: 866-560-9069

****PLEASE PRINT****