SVCMC, Inc. | US FAMILY HEALTH PLAN

US FAMILY HEALTH PLAN
PRIOR AUTHORIZATION FORM

Fill out this form ONLY IF the requested service requires prior authorization approval.
Fax the completed form to 866-337-8690.

Phone: (866) 560-9069
Fax: (866) 337-8690

SECTION 1. REQUEST TYPE

Check one type: ☐ Standard / Routine Request ☐ Expedited / Urgent Request* ☐ Retroactive Request

* For an Expedited/Urgent Request, must provide rationale in this box.

***Definition of Expedited/Urgent:** The delay of treatment could jeopardize the life and health of patient, jeopardize patient's ability to regain maximum function or subject patient to severe pain that cannot be adequately managed without the care or treatment requested.*

SECTION 2. MEMBER/BENEFICIARY & OTHER HEALTH INSURANCE (OHI) INFORMATION

Last Name	First Name	MI	DOB (MM/DD/YYYY)

Member ID #	Sex ☐ Male ☐ Female	Telephone Number

Address (No. and Street)	City

State	Zip Code	Email Address

Does the patient have other health Insurance (OHI)? ☐ Yes ☐ No

If Yes, provide the following details: OHI Payer Name (if known):

OHI Policy # (if known): OHI Phone # (if known):

SECTION 3. REFERRING & SERVICING PROVIDER INFORMATION

	Referring Provider	***Servicing / Rendering Provider***
Practitioner / Facility Name		
NPI & Tax ID (TIN)	NPI: TIN:	NPI: *(if known)* TIN: *(if known)*
Specialty / Facility Type		
Provider Address	Street: City: State: Zip Code:	Street: City: State: Zip Code:
Contact Person & Secure Email	Name: Email:	Name: Email:
Phone & Secure Fax to Receive Determination	Tel: Fax:	Tel: Fax:

Upon USFHP's decision, determination letters will be faxed to BOTH referring and servicing providers.

SECTION 4. SERVICE CATEGORY, DIAGNOSES & PROCEDURE DETAILS

Service Category: Check all that apply

- ☐ Inpatient / Surgical
- ☐ Outpatient ASC
- ☐ Advanced Imaging
- ☐ DME / Supplies
- ☐ SNF / Rehab
- ☐ PT / OT / ST
- ☐ Home Health
- ☐ Infusion / J-Code
- ☐ Office Visit
- ☐ Mental Health
- ☐ Hospice
- ☐ Other:_____

Primary ICD-10 Code:

Primary Diagnosis Description:

Secondary ICD-10 Code:

Secondary Diagnosis Description:

Discipline/ Service	Setting	CPT/HCPCS Codes	Modifier	Number of Visits	Number of Units	Frequency	Start Date	End Date

SECTION 5. MANDATORY CLINICAL DOCUMENTATION SUBMISSION CHECKLIST (As Applicable)

- ☐ **Clinical Progress Notes (Past 30-90 days):** History, physical exam findings, vital signs, deficits.
- ☐ **Diagnostic & Lab Reports:** Relevant imaging (MRI/CT/X-ray), pathology, specific lab values.
- ☐ **Therapy Care Plan:** Baseline functional scores, standardized metrics, measurable goals.
- ☐ **Conservative Treatment History:** Documented trial, duration, and failure of prior therapies.
- ☐ **DME / Supplies:** Itemized manufacturer quote, HCPCS codes, Letter of Medical Necessity.
- ☐ **Specialty Drug / J-Code:** Weight/BSA, FDA indication, failed prior medications.
- ☐ Other Clinical Rationale or Medical Necessity for Requested Service. _____

SECTION 6. LEGAL DISCLAIMER & PROVIDER ATTESTATION

ACKNOWLEDGEMENT OF LEGAL DISCLAIMER: Toney Healthcare Consulting (THC) is the acting utilization review agent for USFHP. THC authorization determinations are based solely on the clinical information provided herein and are not a guarantee of payment or coverage. Benefits are subject to member eligibility and Plan limitations at the time of service. Final payment determinations shall be made in accordance with US Family Health Plan (TRICARE) policy guidelines.

PROVIDER ATTESTATION: I attest that the treatment plan and requested services are medically necessary, appropriate, and approved by the ordering provider.

Ordering Provider Printed Name: _____

Authorized Signature: _____

Date (MM/DD/YYYY): _____

CONFIDENTIALITY NOTICE: This fax/electronic transmission and its attachments may contain PRIVILEGED and CONFIDENTIAL INFORMATION and/or PROTECTED PATIENT HEALTH INFORMATION (PHI) intended solely for the use of US Family Health Plan and the recipient(s) named above. If you are not the intended recipient, employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any review, disclosure, distribution, dissemination, printing or copying of this fax transmission and /or any attachments is strictly prohibited. If you have received this transmission in error, please notify the sender immediately and permanently delete and destroy this document and any attachments.