REQUEST FOR AUTHORIZATION OF SERVICES

EMAIL or FAX THIS FORM

Email: UM@LibertyMedicareAdvantage.com Fax:

1-877-760-8320 For questions: 1-844-854-6884

☐ Standard ☐ Expedited/Medically Urgent* ☐ Retro

Provider/Facility

Prescribing Provider Name:____ NPI:________________
Name and Credentials of person making request: ____
Phone:_____________________Fax:_____________________Email:___________________________
Servicing Provider/Facility :____ NPI:________________
Inpatient Admission Date: ____/____/____ Estimated Length of Stay: _________ days
Part A SNF (post hospitalization) ____/____/____ Estimated Length of Stay: _________ days
Part A Skill-in-Place ____/____/____ Estimated Length of Stay: _________ days
Additional Part A Days:_______________ Reason:____
Outpatient Diagnostic/Service: ____/____/____ CPT: _______________________________________
Part B Drug: ____
DME: ____

Member Data

Name: ____ Date of Birth: ____________________
Plan ID/MBI: ______________________________________
Nursing Facility: ____
Is Requesting Provider : ☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other____________________________

Diagnosis (ICD10) Related to Request:____

Part B/Therapy

REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

☐ **PT** Initial Visits Date of Eval ____/____/____ Plan: ____ days per week for ____ weeks
Goals in Place ___Yes ___ No
☐ Additional PT Visits # requested ______________ Plan: ____ days per week for ____ weeks
Goals Updated ___Yes ___ No
Member Actively Participating? ___Yes ___ No Functional Progress Made? ___Yes ___ No Demonstrates Potential to Improve? ___Yes ___ No

☐ **OT** Initial Visits Date of Eval ____/____/____ Plan: ____ days per week for ____ weeks
Goals in Place ___Yes ___ No
☐ Additional OT Visits # requested ______________ Plan: ____ days per week for ____ weeks
Goals Updated ___Yes ___ No
Member Actively Participating? ___Yes ___ No Functional Progress Made? ___Yes ___ No Demonstrates Potential to Improve? ___Yes ___ No

☐ **ST** Initial Visits Date of Eval ____/____/____ Plan: ____ days per week for ____ weeks
Goals in Place ___Yes ___ No
☐ Additional ST Visits # requested ______________ Plan: ____ days per week for ____ weeks
Goals Updated ___Yes ___ No
Member Actively Participating? ___Yes ___ No Functional Progress Made? ___Yes ___ No Demonstrates Potential to Improve? ___Yes ___ No

* I CERTIFY BY SIGNING BELOW THAT WAITING FOR A DECISION LONGER THAN 72 HOURS COULD PLACE THE MEMBER'S LIFE, HEALTH, OR ABILITY TO GAIN MAXIMUM FUCTION IN SERIOUS JEOPARDY.
NAME: (print) ______________________________ SIGNATURE: ____

PLEASE DO NOT SEND REQUEST FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX--MUST SEND SEPARATELY