REQUEST FOR AUTHORIATION OF SERVICES

EMAIL or FAX THIS FORM

Liberty ADVANTAGE
Planning your advantage

Email: auths@accesshealth.services

Fax: 1-800-413-8347 For questions: 1-844-857-1601

☐ Standard ☐ Expedited/Medically Urgent* ☐ Retro **DATE:**_____

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