SIMPRA ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

UM Phone: 1-844-637-4770 UM Fax: 251-725-5099

Only one request per fax is permitted.

Simpra Advantage
PARTNERS IN WELLNESS

Do NOT Use This Form to Request Home Health

Clear Form | Print

SECTION I — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent			
Clinical Reason for Urgency:			
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	

SECTION II — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Simpra Member ID #:	Group #:	

SECTION III — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION IV — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version ___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other:

☐ Skilled Nursing ☐ Initial ☐ Additional Visits Frequency: Duration:
Eval. Date: Proj. D/C Date: ☐ Part A ☐ Part B ☐ Skill in Place ☐ Other/ICD-10:

☐ Physical Therapy ☐ Initial ☐ Additional Visits Frequency: Duration:
Eval. Date: Proj. D/C Date: ☐ Part A ☐ Part B ☐ Skill in Place ☐ Other/ICD-10:

☐ Occupational Therapy ☐ Initial ☐ Additional Visits Frequency: Duration:
Eval. Date: Proj. D/C Date: ☐ Part A ☐ Part B ☐ Skill in Place ☐ Other/ICD-10:

☐ Speech Therapy ☐ Initial ☐ Additional Visits Frequency: Duration:
Eval. Date: Proj. D/C Date: ☐ Part A ☐ Part B ☐ Skill in Place ☐ Other/ICD-10:

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)
Equipment/Supplies (include any HCPCS Codes): Duration:

SECTION V — CLINICAL DOCUMENTATION