

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.

Do NOT Use This Form to Request Home Health

SECTION I — GENERAL INFORMATION

Review Type:	Non-Urgent	Urgent	Continuation of Care	Notification Only
Clinical Reason for Urgency:				
Request Type:	Initial Request	Extension/Renewal/Amendment	Prev. Auth. #:	

SECTION II — PATIENT INFORMATION

Name:	Phone:	DOB:	Male Other	Female 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:		
Start Date:	Proj. D/C Date:	Part A	Part B	Skill in Place	Other/ICD-10:	
Physical Therapy	Initial	Additional Visits	Frequency:	Duration:		
Start Date:	Proj. D/C Date:	Part A	Part B	Skill in Place	Other/ICD-10:	
Occupational Therapy	Initial	Additional Visits	Frequency:	Duration:		
Start Date:	Proj. D/C Date:	Part A	Part B	Skill in Place	Other/ICD-10:	
Speech Therapy	Initial	Additional Visits	Frequency:	Duration:		
Start 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

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