

SIMPRA ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM FOR HOME HEALTH SERVICES

UM Phone: 1-844-637-4770 UM Fax: 659-223-0766

Only one request per fax is permitted.



SECTION I — GENERAL INFORMATION

Review Type:	Non-Urgent	Urgent	
Clinical Reason for Urgency:			
Request Type:	Initial Request	Recertification	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 SERVICE CODES) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Please do not leave any item blank. We need to know the dates of service and total number of visits for the service you select.

Skilled Nursing		# Visits/week:	
Service Code:	From Date:	To Date:	Total # of visits:
Physical Therapy		# Visits/week:	
Service Code:	From Date:	To Date:	Total # of visits:
Occupational Therapy		# Visits/week:	
Service Code:	From Date:	To Date:	Total # of visits:
Speech Therapy		# Visits/week:	
Service Code:	From Date:	To Date:	Total # of visits:

SECTION V — CLINICAL DOCUMENTATION and/ or ADDITIONAL DISCIPLINES/SERVICES NEEDED