

## REQUEST FOR AUTHORIZATION OF SERVICES FORM

Call UM at 844-637-4770 opt 3 (Call Center Hours M-F 8a– 5p)

FAX Form and Clinical to 800-547-6503  
or email to [UMInquiryRequest@Simpra.com](mailto:UMInquiryRequest@Simpra.com)

**\*\*\* PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY**

**\*PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

<b>MEMBER DATA</b>	<p>Member Name _____ Date of Birth _____ Member's Plan ID _____</p> <p>Name of Nursing Facility _____ Referring Provider _____ Is Referring Provider: <input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other</p> <p>Diagnoses (ICD-10 Codes) Related to Auth Request _____</p>
<b>PART A and OUTPATIENT SERVICE</b>	<p><b>SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)</b></p> <p><input type="checkbox"/> Part A SNF (post hospitalization) Start Date _____ # of Days Requested _____</p> <p><input type="checkbox"/> Part A Skill-in-Place Start Date _____ # of Days Requested _____</p> <p><input type="checkbox"/> Additional Part A Days Reason: _____ # of Days Requested _____</p> <p><input type="checkbox"/> Outpatient Diagnostic or Service Date of Procedure/Service _____</p> <p>CPT Code or Name of Procedure/Service: _____</p> <p>Provider or Facility Name (REQUIRED): _____</p> <p>Provider or Facility Contact Number (REQUIRED): _____</p>
<b>PART B / THERAPY</b>	<p><b>REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)</b></p> <p><input type="checkbox"/> <b>PT</b> <input type="checkbox"/> Initial Visits Start of Care _____ Plan: ____ days per week for ____ week(s) Goals in Place? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Additional <b>PT</b> Visits # requested _____ Plan: ____ days per week for ____ week(s) Goals updated? <input type="checkbox"/> Y <input type="checkbox"/> N Member Actively Participating? <input type="checkbox"/> Y <input type="checkbox"/> N Functional Progress Made? <input type="checkbox"/> Y <input type="checkbox"/> N Demonstrates Potential to Improve? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> <b>OT</b> <input type="checkbox"/> Initial Visits Start of Care _____ Plan: ____ days per week for ____ week(s) Goals in Place? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Additional <b>OT</b> Visits # requested _____ Plan: ____ days per week for ____ week(s) Goals updated? <input type="checkbox"/> Y <input type="checkbox"/> N Member Actively Participating? <input type="checkbox"/> Y <input type="checkbox"/> N Functional Progress Made? <input type="checkbox"/> Y <input type="checkbox"/> N Demonstrates Potential to Improve? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> <b>ST</b> <input type="checkbox"/> Initial Visits Start of Care _____ Plan: ____ days per week for ____ week(s) Goals in Place? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Additional <b>ST</b> Visits # requested _____ Plan: ____ days per week for ____ week(s) Goals updated? <input type="checkbox"/> Y <input type="checkbox"/> N Member Actively Participating? <input type="checkbox"/> Y <input type="checkbox"/> N Functional Progress Made? <input type="checkbox"/> Y <input type="checkbox"/> N Demonstrates Potential to Improve? <input type="checkbox"/> Y <input type="checkbox"/> N</p>

**TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION**

Standard Authorization Request

Expedited Authorization (Must Read and SIGN): By signing below I certify that waiting for a decision longer than 72 hours **could** place the Member's life, health, or ability to gain maximum function in serious jeopardy.

Signature for Expedited Review Only: \_\_\_\_\_

Name of Person Completing this Form: \_\_\_\_\_ Date Completed: \_\_\_\_\_  
(Please Print Name)

Contact #: \_\_\_\_\_ Contact FAX: \_\_\_\_\_