EMAIL THIS FORM TO **SimpraUM@allyalign.com**.

Simpra Advantage
PARTNERS IN WELLNESS

****SIMPRA SPECIAL PART A/B REQUEST****

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR CERTAIN SERVICES. 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.

MEMBER DATA

Member Name _____ Date of Birth _____ Health Plan ID _____

Nursing Facility _____ Referring Provider _____ Is Referring Provider: ☐ NP / PA ☐ PCP ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request _____

AUTHORIZATION/ REQUEST

SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)

☐ Skilled Nursing Care Post Hospital or ER Reason _____ Start Date: _____ Number of Days Requested _____

☐ Skill-in-Place services Reason _____ Start Date: _____Number of Days Requested _____

☐ Continuation/Additional Days: Reason:_____ Number of Days Requested: _____

☐ Transportation Services (Exception Basis Only – Not a Defined Simpra Benefit):
☐ Facility Van ☐ Outside Provider (List Name) _____

☐ Diagnostic Testing or Procedure (List Type and CPT CODE) _____
☐ In Facility ☐ Out of Facility List Provider/Facility: _____
Scheduled Date for Services (if scheduled)_____

THERAPY REQUEST

REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

Request for ☐ PT ☐ OT ☐ ST ☐ Other _____
☐ Initial Evaluation ☐ Therapy Treatment Plan ☐ Additional Therapy Days ☐ In Progress
Date of injury/illness:_____ Start of Care: _____ Date of Last Exam: _____
# of Therapy Units Requested:_____ _____Times per week For_____weeks
Reason for Request: _____
Significant Improvement Has Been Made ☐ Yes ☐ No Rehab Potential ☐ Fair ☐ Good ☐ Excellent

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ Standard Authorization: Most services if requested by or with a written order from a PCP or Plan NP are "auto-authorized" within 8 hours or less. CMS allows 14 days for standard authorizations. Our goal is 5-7 days.

☐ Expedited Authorization (Must Read and SIGN): By signing below I certify that waiting for a decision under the standard time frame could place the Member's life, health, or ability to gain maximum function in serious jeopardy.

Signature _____

Name of Person Completing this Form:_____Date Completed: _____
Contact #:_____Contact FAX: _____

PCP/NP SIGNATURE: _____ (Required)

10/22/2019