



REQUEST FOR SERVICES REQUIRING PRE AUTHORIZATION

Member Name: _____	REFERRED TO: _____
Simply Healthcare Plans ID #: _____	SPECIALTY: _____
Member DOB: ____ / ____ / ____ Telephone: (____) ____ - ____	REFERRED TO PROVIDER ID #: _____
PCP Name: _____	REFERRED TO FAX #: (____) _____
PCP ID #: _____ Telephone: (____) ____ - ____	DIAGNOSIS (ICD-9): _____, _____, _____, _____
REFERRING PHYSICIAN NAME: _____	CPT CODES: _____, _____, _____, _____
CONTACT PERSON: _____	REASON FOR REFERRAL: _____
REFERRING PHYSICIAN TELEPHONE: (____) _____	_____
REFERRING PHYSICIAN FAX NUMBER: (____) _____	_____
<input type="checkbox"/> Simply Healthcare Medicaid	_____

Request Type:

Routine (Up to 14 Calendar Days from the receipt date)

STAT/URGENT (72 HOURS) **IMPORTANT NOTE:** A STAT/URGENT request for an organization determination is defined as a request that waiting for a decision under the Routine time frame **could place the member's life, health, or ability to regain maximum function in serious jeopardy.** STAT/Urgent Requests must be phoned in to the Plan's Pre-Certification Team (see below)

Initial (First) Request 2nd Request 3rd Request

IS THIS REQUEST RELATED TO AN ACCIDENT? YES NO DOES THIS MEMBER HAVE OTHER INSURANCE COVERAGE? YES NO

MVA WORKER'S COMPENSATION MEDICARE OTHER (SPECIFY): _____

THE FOLLOWING SERVICES REQUIRE PRE-AUTHORIZATION--PLEASE SUBMIT SUPPORTING CLINICAL DOCUMENTATION TO DETERMINE MEDICAL NECESSITY:

INPATIENT SERVICES:	OUTPATIENT SERVICES:
<input type="checkbox"/> HOSPITAL ADMISSIONS	<input type="checkbox"/> PET SCANS <input type="checkbox"/> MRA
<input type="checkbox"/> BIRTHING CENTERS	<input type="checkbox"/> MRI <input type="checkbox"/> PHYSICAL THERAPY
<input type="checkbox"/> 23-HOUR OBSERVATION	<input type="checkbox"/> Sleep Studies <input type="checkbox"/> WOUND CARE
OUTPATIENT SURGICAL SERVICES:	<input type="checkbox"/> TOTAL OB CARE
<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SPEECH, OCCUPATIONAL OR RESPIRATORY THERAPIES:
<input type="checkbox"/> AMBULATORY SURGICAL CENTER	FOR MEMBERS UNDER 21 YEARS OF AGE ONLY
OUTPATIENT SERVICES PERFORMED AT A HOSPITAL:	<input type="checkbox"/> CHEMOTHERAPY
<input type="checkbox"/> COLONOSCOPY	<input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> HYPERBARIC OXYGEN TREATMENT	<input type="checkbox"/> DURABLE MEDICAL EQUIPMENT (DME)- FAX REQUESTS TO ALLMED AT:
<input type="checkbox"/> ENDOSCOPY	800-831-4264
<input type="checkbox"/> WOUND CARE	<input type="checkbox"/> HOME HEALTH SERVICES
<input type="checkbox"/> ALL THERAPY AND REHABILITATIVE SERVICES	<input type="checkbox"/> INFUSION SERVICES

- Please FAX to: Simply Healthcare at (305) 408-5810 or (800) 283-2117
 - STAT/URGENT Requests: Please do NOT fax the request. Call Simply Healthcare's Pre-Certification Telephone Queue and advise that the request is to be a STAT/URGENT Request at: (877) 915-0551, Prompt 2
- *****PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT*****