CLEAR HEALTH ALLIANCE
Offered by simply healthcare

simply healthcare

better health

REQUEST FOR SERVICES REQUIRING PRIOR AUTHORIZATION
FAX 1-800-283-2117
TELEPHONE NUMBER 1-877-915-0551, OPTION 2

DME/HH/INFUSION SRVC

FAX: 1-855-461-0629

Member Name: _____

Circle Plan Name: Simply Better Clear Health

Health Plan ID #: _____

Member DOB: ____/____/____ Phone: (___)_____-_____

PCP Name: _____

PCP ID #: _____ Phone: (___)_____-_____

REFERRING PHYSICIAN NAME: _____

CONTACT PERSON: _____

REFERRING PHYSICIAN TELEPHONE: (___)_____

REFERRING PHYSICIAN FAX NUMBER: (___)_____

REFERRED TO: _____

SPECIALTY :___ _____

APPOINTMENT DATE: _____

REFERRED TO : PROVIDER ID #: _____

REFERRED TO FAX #: (_____)_____

DIAGNOSIS (ICD): _____, _____, _____, _____

CPT CODES: _____, _____, _____, _____

REASON FOR REFERRAL: _____

_____

_____

Request Type: ☐ Standard ☐ Expedited/Urgent By checking this box I certify that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to regain maximum function. You may call our Pre-Certification department and advise the request is Expedited/Urgent at 1-877-915-0551, option 2

IMPORTANT NOTE: *An Expedited/Urgent request for a determination is a request in which waiting for a decision under the Standard time frame* ***could place the member's life, health, or ability to regain maximum function in serious jeopardy***.

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

☐ MVA ☐ LONG TERM CARE MANAGED CARE ☐ WORKER'S COMPENSATION ☐ MEDICAID ☐ Medicare ☐ Other INSURANCE (SPECIFY):_____

THE FOLLOWING SERVICES REQUIRE PRE-AUTHORIZATION--PLEASE SUBMIT SUPPORTING CLINICAL DOCUMENTATION TO DETERMINE MEDICAL NECESSITY, TO INCLUDE RECENT OFFICE VISITS, DIAGNOSIS CODES AND ANY PERTINENT RECENT X-RAY OR LAB REPORTS.

INPATIENT SERVICES:

- ☐ HOSPITAL ADMISSIONS
- ☐ BIRTHING CENTERS
- ☐ OBSERVATION

OUTPATIENT SURGICAL SERVICES:

- ☐ HOSPITAL
- ☐ AMBULATORY SURGICAL CENTER

OUTPATIENT SERVICES PERFORMED AT A HOSPITAL:

- ☐ COLONOSCOPY
- ☐ ENDOSCOPY
- ☐ WOUND CARE
- ☐ HYPERBARIC OXYGEN TREATMENT
- ☐ ALL THERAPY AND REHABILITATIVE SERVICES
- ☐ ANY OTHER HOSPITAL SERVICES

OUTPATIENT SERVICES:

- ☐ PET SCAN ☐ MRA
- ☐ MRI ☐ PHYSICAL THERAPY
- ☐ Sleep Study ☐ WOUND CARE
- ☐ TOTAL OB CARE **LMP**:_____ **EDD:**_____
- ☐ SPEECH, OCCUPATIONAL OR RESPIRATORY THERAPIES (ST/OT/RT):
- ☐ CHEMOTHERAPY
- ☐ RADIATION THERAPY
- ☐ DURABLE MEDICAL EQUIPMENT (DME):

  FAX REQUESTS TO 1-855-461-0629
- ☐ HOME HEALTH SERVICES AND INFUSION SERVICES:

  FAX REQUESTS TO 1-855-461-0629

*****PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT*****