

**REQUEST FOR SERVICES REQUIRING PRE AUTHORIZATION**

<p>Member Name: _____</p> <p>Better Health ID #: _____</p> <p>Member DOB: ___/___/___ Telephone: (____) _____ - _____</p> <p>PCP Name: _____</p> <p>PCP ID #: _____ Telephone: (____) _____ - _____</p> <p>REFERRING PHYSICIAN NAME: _____</p> <p>CONTACT PERSON: _____</p> <p>REFERRING PHYSICIAN TELEPHONE: (____) _____</p> <p>Referring physician fax number: _____</p>	<p>REFERRED TO: _____</p> <p>REFERRED TO BETTER HEALTH ID #: _____</p> <p>REFERRED TO FAX #: (____) _____</p> <p>DIAGNOSIS (ICD-9): _____, _____, _____, _____</p> <p>CPT CODES: _____, _____, _____, _____</p> <p>REASON FOR REFERRAL: _____</p> <p>_____</p> <p>REQUESTED: <input type="checkbox"/> ROUTINE (14 CALENDAR DAYS) <input type="checkbox"/> STAT/URGENT (48 HRS)</p>
<p><b>THE FOLLOWING SERVICES REQUIRE PREAUTHORIZATION--PLEASE SUBMIT WITH SUPPORTING CLINICAL DOCUMENTATION TO DETERMINE MEDICAL NECESSITY:</b></p> <p><b>INPATIENT SERVICES:</b></p> <p><input type="checkbox"/> HOSPITAL ADMISSIONS</p> <p><input type="checkbox"/> ACUTE REHABILITATION ADMISSIONS</p> <p><input type="checkbox"/> SKILLED NURSING FACILITY (SNF) ADMISSIONS</p> <p><input type="checkbox"/> BIRTHING CENTERS</p> <p><input type="checkbox"/> 23 HOUR OBSERVATION</p> <p><b>OUTPATIENT SURGICAL SERVICES:</b></p> <p><input type="checkbox"/> HOSPITAL</p> <p><input type="checkbox"/> AMBULATORY SURGICAL CENTER</p> <p><b>OUTPATIENT SERVICES PERFORMED AT A HOSPITAL:</b></p> <p><input type="checkbox"/> COLONOSCOPY</p> <p><input type="checkbox"/> ENDOSCOPY</p> <p><input type="checkbox"/> WOUND CARE</p> <p><input type="checkbox"/> Hyperbaric Oxygen Treatment</p> <p><input type="checkbox"/> ALL THERAPY AND REHABILITATIVE SERVICES</p> <p><b>OUTPATIENT SERVICES:</b></p> <p><input type="checkbox"/> PET SCANS <span style="margin-left: 150px;"><input type="checkbox"/> PHYSICAL THERAPY</span></p> <p><input type="checkbox"/> MRA <span style="margin-left: 150px;"><input type="checkbox"/> CHEMOTHERAPY-INCLUDE J CODES</span></p> <p><input type="checkbox"/> RADIATION THERAPY <span style="margin-left: 150px;"><input type="checkbox"/> SLEEP STUDIES</span></p> <p><input type="checkbox"/> OCCUPATIONAL THERAPY <span style="margin-left: 150px;"><input type="checkbox"/> RESPIRATORY THERAPY</span></p> <p><input type="checkbox"/> WOUND CARE</p> <p><input type="checkbox"/> DURABLE MEDICAL EQUIPMENT (DME)</p> <p><input type="checkbox"/> SPEECH/LANGUAGE PATHOLOGY THERAPY</p> <p><input type="checkbox"/> SKILLED NURSING SERVICES, INCLUDING HOME HEALTH, HOME HEALTH AIDE, PHYSICAL THERAPY SERVICES</p>	<p><input type="checkbox"/> INITIAL REQUEST <span style="margin-left: 100px;"><input type="checkbox"/> 2<sup>ND</sup> REQUEST</span> <span style="margin-left: 100px;"><input type="checkbox"/> 3<sup>RD</sup> REQUEST</span></p> <p><b>IS THIS REQUEST RELATED TO AN ACCIDENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 40px;"><input type="checkbox"/> MVA <span style="margin-left: 100px;"><input type="checkbox"/> WORKER'S COMPENSATION</span></p> <p><b>DOES THIS MEMBER HAVE OTHER INSURANCE COVERAGE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="margin-left: 40px;"><input type="checkbox"/> MEDICARE <input type="checkbox"/> OTHER (SPECIFY): _____</p> <p style="margin-left: 40px;">_____</p> <ul style="list-style-type: none"> <li><b>PLEASE FAX TO: BETTER HEALTH 800-283-2117</b> <b>OR 305- 408-5810</b></li> <li><b>For STAT/Urgent Requests, it is suggested that requests be called to the Better Health PreCertification Telephone Queue at (800) 887-6888, Extension 2271</b></li> <li><b>Please include State requirements information for Hysterectomy and Abortion</b></li> </ul>
	<p><b>FOR BETTER HEALTH OFFICE USE ONLY:</b></p> <p><b>DATE REQUEST RECEIVED:</b> _____</p> <p><b>STATUS:</b> <input type="checkbox"/> APPROVED – AUTHORIZATION #: _____</p> <p style="margin-left: 40px;"><input type="checkbox"/> DENIED (REASON): _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;"><input type="checkbox"/> PENDED (REASON): _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">_____</p> <p><b>DATE FAXED TO REQUESTING PROVIDER:</b> _____</p>
<p><i>PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT</i></p>	