MoreCare®

A Medical Home Network Affiliate

Fax Completed Form to: 888-522-6952

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Requestor's Contact Name: | | | | | Requestor's Contact #: | | | | | | |
| **Patient Information:** | | | | | | | | | | | |
| *Name: | | | | | *DOB: | | | | | | |
| *Member ID #: | | | | | *Member Phone #: | | | | | | |
| Work Related Injury? | ☐ | Yes | ☐ | No | Motor Vehicle Accident related injury? | ☐ | Yes | ☐ | No | | |
| Does the member have other insurance? | ☐ | Yes | ☐ | No | If Yes, other insurer | | | | | | |
| Does the member have Medicare? | ☐ | Yes | ☐ | No | If Yes, | ☐ | Part A | ☐ | Part B | | |
| *Service Is: | ☐ | Elective / Routine | ☐ | Expedited / Urgent | | | | | | | |

**Note:** Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.

Claim Denial or Prior Authorization Denial: submit Appeal via Appeals Dept. ph 844-865-8033. Members: call 844-480-8528

***Referral Service Type Requested:** Please review plans benefit prior to request

| Inpatient | Outpatient | Behavioral Health | Other |
|---|---|---|---|
| ☐ Emergent Inpatient | ☐ Surgical Procedure | ☐ Inpatient | ☐ Home Health /Skilled Services (SN/PT/OT/SP) |
| ☐ Concurrent Review | ☐ PT, OT, ST | ☐ Partial Hospitalization | ☐ Private Duty Nursing (see PDN specific form) |
| ☐ Surgical Procedures | ☐ Imaging | ☐ Intensive Outpatient (IOP) | ☐ DME |
| ☐ Elective Admission | ☐ Chiropractic | ☐ Residential Treatment | ☐ Transportation / Transfers |
| ☐ Elective Observation | ☐ Acupuncture | ☐ Chemical Dependency | ☐ Air Ambulance |
| ☐ SNF | ☐ Hospice | ☐ Office Visit | ☐ Other: |
| ☐ Rehab | | ☐ Other Therapy: | |
| ☐ Maternity | | | |
| ☐ NICU | | | |
| ☐ Hospice | | | |

| | | |
|---|---|---|
| **Procedure Information:** | | |
| ***ICD 10** Diagnosis: | Diagnosis Description: | |
| ***CPT/HCPC** Code & Description *(Include Unit of Measure / Frequency for supplies):* | | |
| *Date(s) of Service: | Number of Visits: | |
| **Provider Information:** | | |
| **Ordering Provider** | Is this the member's Primary Care Provider? ☐ Yes ☐ No | |
| *Name: | *NPI | TIN: |
| *Phone: | *Fax | |
| *Address: | | |
| **Servicing Provider** | Is this the same as the Ordering Provider? ☐ Yes ☐ No | |
| ***If not complete below:*** | | |
| *Name | *NPI | TIN: |
| *Phone | *Fax: | |
| *Address | | |
| **Facility** | | |
| *Name: | *NPI | TIN: |
| *Phone | *Fax | |
| *Address | | |

***Request for extension to authorization request:***

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Always verify eligibility, benefits and prior authorization requirements