PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Request Date: _____

Prior Authorization/Benefit Certification Request Form

Prior Authorization Fax: (505) 843-3047 / Inpatient Admission Fax: (505) 843-3107 / UNM Fax: (505) 843-3108

☐ **Routine**

☐ **Urgent or Expedited Initial Determination**

For a Prior Authorization/Benefit Certification request to be considered "Urgent" or "Expedited," check all that apply. Please note: Requests that do not meet this criteria may be processed as routine requests.

- ☐ The life or health of a covered person would be jeopardized
- ☐ The covered person's ability to regain maximum function would be jeopardized
- ☐ The medical exigencies of the case require an expedited decision

Practitioner Signature: _____ **(Required for Urgent or Expedited requests)**

Complete the information below and attach all of the clinical information pertinent to the request.

Member Name: _____ **ID Number:** _____ **DOB:** _____

Contact Person: _____ **Phone:** _____ **Fax:** _____

Requesting Provider: _____ **Phone:** _____ **Fax:** _____

Servicing Provider/Facility: _____ **Phone:** _____ **Fax:** _____

Servicing Provider/Facility Address: _____

Tax ID/NPI #: _____ _____

Services requested

☐ New/Initial Request ☐ Ongoing Care Previous Certification Number: _____

☐ DME/Prosthetic/Orthotic ☐ Ambulatory/Outpatient Surgery ☐ Office ☐ SNF ☐ Home Birth

☐ Out-of-Plan Services ☐ Inpatient LOS: _____ Facility: _____

☐ Pres Online Request/Clinical Information ☐ Prescription Attached ☐ Clinical Information Attached

☐ Health Help unable to process ☐ Other: _____

Diagnosis(es) (ICD-10) (Required): _____ _____ _____ _____ _____

Procedure(s) (CPT/HCPC) (Required): _____ _____ _____ _____ _____

Requested Effective Date: _____ **End Date:** _____ **Number of Visits/Units:** _____

Symptoms and Summary of Previous Treatment:

_____

_____

_____

For more information, please review the Prior Authorization/Benefit Certification Guide at www.phs.org/providers/authorizations

CONFIDENTIAL: PROTECTED HEALTH INFORMATION ENCLOSED. Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure of failure to maintain confidentiality could subject you to penalties described in federal and state law.