SUNRISE ADVANTAGE PLAN

# *REQUEST FOR AUTHORIZATION OF SERVICES FORM*

***Call* UM at NY: 844-896-0628 IL: 844-502-4149 opt 3 (Call Center Hours M-F 8a– 5p)** ***FAX* Form and Clinical to 800-504-4752**

****** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY***

***PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

## MEMBER DATA

**Member Name** _____ **Date of Birth** _____ **Member's Plan ID** _____

**Name of Nursing Facility** _____ **Referring Provider** _____ Is Referring Provider: ☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other

**Diagnoses (ICD-10 Codes) Related to Auth Request** _____

## PART A and OUTPATIENT

**SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)**

☐ **Part A SNF (post hospitalization)** **Start Date**_____ **# of Days Requested** _____

☐ **Part A Skill-in-Place** **Start Date**_____ **# of Days Requested** _____

☐ **Additional Part A Days** **Reason:** _____ **# of Days Requested**_____

☐ **Outpatient Diagnostic or Service** **Date of Procedure/Service**_____

**CPT Code or Name of Procedure/Service**: _____

**Provider or Facility Name (REQUIRED):** _____

**Provider or Facility Contact Number (REQUIRED)**: _____

## PART B / THERAPY

**REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)**

☐ **PT** ☐ Initial Visits Date of Eval_____ Plan: ____ days per week for _____ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **PT** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐ N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

☐ **OT** ☐ Initial Visits Date of Eval_____ Plan: ____ days per week for ___ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **OT** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐ N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

☐ **ST** ☐ Initial Visits Date of Eval_____ Plan: ____ days per week for _____ week(s) Goals in Place? ☐ Y ☐ N

☐ Additional **ST** Visits # requested_____ Plan: ____ days per week for _____ week(s) Goals updated? ☐ Y ☐ N

Member Actively Participating? ☐ Y ☐N Functional Progress Made? ☐ Y ☐ N Demonstrates Potential to Improve?☐Y ☐ N

**TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION**

☐ **Standard Authorization Request**

☐ **Expedited Authorization (Must Read and SIGN)**: By signing below I certify that waiting for a decision longer than 72 hours **could place the Member's life, health, or ability to gain maximum function in serious jeopardy**.

**Signature for Expedited Review Only**: _____

**Name of Person Completing this Form:**_____ **Date Completed:** _____

**(Please Print Name)**

**Contact #:** _____ **Contact FAX:** _____