Community*care* PLAN
the health plan with a heart

PRE-CERTIFICATION/AUTHORIZATION FORM:
For Registered Providers with EPIC Link, please use the web portal to Request prior-authorization of medical services.
Phone 1-866-899-4828 I Fax: 1-844-870-0159
Line of Business: ▫ MMA (Medicaid)

Priority: ▫ **EXPEDITED** (up to 3 business days) When a provider indicates, or the Managed Care plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life, health or ability to attain, maintain or regain maximum function.

▫ **STANDARD** (up to 14 calendar days)

All applicable fields must be completed for faster processing 1 ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTII

MEMBER'S INFORMATION

Member's Name:	D.O.B:
Member's Medicaid ID	Phone:
Member's Address:	

REQUESTING PROVIDER INFORMATION (check one) ▫ **PCP** ▫ **Specialist**

Office Contact Name:	Phone:	Fax:
Provider's Name:	Specialty:	
Signature:	Date Form Completed:	

REFERRED TO PROVIDER (check one) ▫ **In-Network** ▫ **Out-of-Network**

Provider/Facility Name:	Phone:	Fax:
Address:	Phone:	Fax:

NPI #: _____ TAX ID: _____

REQUESTED SERVICES (check one below) **Date(s) of Service:**

Ambulatory Surgery Center ▫ Chemotherapy ▫ Dialysis ▫ Durable Medical Equipment
▫ Epidural Pain Management ▫ Home Health Services ▫ Hospital Inpatient ▫ Hospital Observation
▫ Hospital Outpatient ▫ Hyperbaric treatment ▫ Obstetrical Global notification ▫ Office
▫ Therapy Services ▫ Transplant related services

Diagnosis:	ICD-10:	
Tests/Procedures:	CPT Code(s):	HCPCS:

Therapy Services: ▫ PT (97110) ▫ OT (97530) ▫ ST (92507) Visits: _____ Weeks: _____ Total Units _____

Clinical Summary/Findings: Please Attach Pertinent Medical Records to Assist in Authorization

Statement to Provider: This authorization is for Medically Necessary Services Only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits and patient eligibility at the time of service. Additionally, it is important that a report of the treatment provided or service(s) recommended be completed on this member and forwarded to the Primary Care Physician within 7 days of services.