2900 North Loop West, Ste. 700
Houston, TX 77092
T: (281) 591-5289 or (888) 292-1923

REQUEST FORM FOR HEALTH CARE SERVICES

Please read all instructions below before completing this form.

Certain services/procedures require precertification from Amerigroup and SCAN for participating and nonparticipating PCPs and specialists. You can access information concerning precertification requirements on the IntegraNet website at https:// integranethealth.com/prior-authorization-requirements

DISCLAIMER: Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to Amerigroup claims payment policies and procedures.

Providers should always verify eligibility prior to rending services by calling the member's health plan.

Intended Use: Use this form is to request authorizations by FAX when an issuer requires prior authorization of a health care service

Do Not use this form to:

1) request an appeal
2) confirm eligibility
3) verify coverage
4) request a guarantee of payment
5) ask whether a service requires prior authorization
6) request prior authorization of prescription drug

Referral Guidelines: Providers must obtain precertification before referring members to nonplan providers. Referring a member to an out-of-network provider may result in the claim being denied with member liability unless urgent, emergent, out of area renal dialysis or if prior authorization was obtained.

Additional Information and Instructions: **Please Print Legibly

Section I – Member (Patient) Information

Include member's name, telephone number, DOB, Member ID number, and gender.

Section II - General Information

NON-URGENT/STANDARD REQUEST: A non-urgent/standard request may take up to 14 days to process. Request will be processed in the order they are received.

URGENT/EXPEDITED REQUEST: An urgent/expedited request may take up to 72 hours to process. Request are processed in the order received**.**

URGENT/EXPEDITED REVIEW IS ONLY AVAILABLE IF THE STANDARD TIME FOR MAKING A DETERMINATION C0ULD SERIOUSLY JEOPARDIZE THE PATIENT'S HEALTH, LIFE OR ABILITY TO REGAIN MAXIMUM FUNCTION.

***Examples of urgent/expedited request, include for are not limited to*:** hospital admissions, following stabilization of an emergency condition, SNF or LTAC request, acute illness or injury where the provider determines the condition is severe enough to warrant an expedited/urgent request to prevent serious deterioration of patient's condition or health.

Section III – Provider Information

- ***Referring Provider Information*** – include the following information: referring provider name, contact number, NPI number, fax number, provider's signature and date
- ***Servicing Provider Information*** – include the following information: servicing provider name, NPI number, phone number, fax number, specialty and patient's PCP information.

Section IV – Services Requested

Section V – Clinical Documentation

- Give a brief narrative of the medical necessity in the space, or in an attached statement.
- Attach supporting clinical documentation (medical records, process notes, lab reports, etc)
- Failure to submit supporting documentation, orders, etc. may extend the review process.

IntegraNet HEALTH

2900 North Loop West, Ste. 700

Houston, TX 77092

T: (281) 591-5289 or (888) 292-1923

FAX REQUEST TO: (281) 405-3431

Date of Referral:

Section I – Patient Information

Name:	Member ID:	DOB:
Phone:	Gender: ◯ Male ◯ Female ◯ Unknown	

Section II – General Information

Review Type: ◯ Non-Urgent ◯ Urgent	Clinical Reason for Urgency:
Request Type: ◯ Initial Request ◯ Extension/Renewal/Amendment	Prev. Auth. #

Section III – Provider Information

Referring Provider or Facility: ◯ **Contracted Provider** ◯ **Non-Contracted Provider**		**Servicing Provider or Facility:** ◯ **Contracted Provider** ◯ **Non-Contracted Provider**	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Address:	City, State, Zip:	Address:	City, State, Zip:
Contact Name:	Phone:	**Primary Care Provider Name:**	**Phone:**
Referring Provider's Signature and Date			**Fax:**

Section IV – Services Requested *****May attach additional sheets if needed***

Diagnosis Description (ICD 10 Version)	**ICD 10 Code**	**Start Date**	**End Date**	**Planned Service of Procedure**	**CPT Code**	**# of Units**	**# of Visits**

◯ Inpatient ◯ Observation ◯ Outpatient ◯Home ◯ Day Surgery ◯ Other (List):

◯ Physical Therapy ◯ Occupational Therapy ◯ Speech Therapy ◯ Wound Care (MD Signed Order Attached?) ◯ Yes ◯ No

Number of Sessions: _____Duration: _____Frequency: _____Other:_____

◯ Home Health (MD Signed Order Attached?) ◯ Yes ◯No (Nursing Assessment Attached?) ◯ Yes ◯ No

Number of Visits: _____Duration: _____Frequency:_____Other:_____

◯ DME ◯ Purchase ◯ Rental (MD Signed Order Attached?) ◯ Yes ◯ No Duration:_____

Section V – Clinical Documentation **Provide a brief narrative of medical necessity. Attach additional supporting documentation.