ABS Automated Benefit Services

Prior Authorization Request Form

CONFIDENTIAL | Fax to (586) 693-4829
If photos need to be sent, please email them to mcacaremgt@abs-tpa.com

Section I - Contact Information

Contact Name | Phone | Fax | Date & Time Submitted ☐ AM ☐ PM

Section II - General Information

Review Type ☐ Standard ☐ Urgent ☐ Elective | Clinical Reason for Urgency:

Request Type ☐ Initial Request ☐ Retroactive Request ☐ Extension/Reconsideration/Amendment of Previous Auth #

Reason for Change:

Inpatient: ☐ hospital ☐ IPR ☐ LTAC ☐ BH ☐ **Extended Care Facility (SAR/SNF)** ☐ **High Tech Radiology** ☐ **Outpatient**

DME: ☐ Purchase ☐ Rent ☐ **Other - specify:**

Section III - Patient Information

Name | Patient Contact Phone | DOB (dd/mm/yyyy)

Subscriber Name (if different) | Member ID | Sex ☐ Female ☐ Male

Other Insurance Coverage

☐ Primary

☐ Secondary

Section IV - Provider Information

Requesting Provider or Facility	Service Provider or Facility (if applicable)
Name	Name
NPI / Specialty	NPI / Specialty
Phone / Fax	Phone / Fax
Address (required for mailing denial letter)	Address (required for processing claim)

Section V - Services Requested

Planned Service/DME/Emergent Admit	CPT Code (NA for IP)	Date of Service /Admit (NA if not scheduled yet)	End Date/ Discharged if needed	Main Diagnosis	ICD 10 Code

Section VI - Additional Clinical Explanation

****Please attach clinical documentation to fax such as signs, symptoms, history, diagnostic test results, consultant recommendations (if applicable), and plan of treatment. Request cannot be processed without this documentation.** Comments:**

Section VII - Response from Payor ☐ Approved ☐ Additional Information Required

Approval Number | Date Range Approved | CPT codes requested not requiring PA, therefore, not reviewed

Prior authorization is provided pending benefits & eligibility on the date of service, experimental/investigational status,and is not a guarantee of benefits/payment.

Comments or Questions from Payor: ☐ Please provide Clinical Info requested in Section VI. Unable to process Request. ☐ Cannot process without CPT/Dx codes ☐ Form not filled out completely. Unable to process Request.

Reviewer: | Date faxed:

PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Please read all instructions before completing the form.
Please fax the form to 586-693-4829
If photos need to be sent, please email them to mcacaremgt@abs-tpa.com

Intended use: When an issuer requires prior authorization of a health care service, use this form to request the authorization **by mail or fax.**

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, or 6) to request a referral to an out of network physician, facility or other health care provider.

Additional information and instructions:

Section I.
Contact information for the person requesting the authorization. This is the person that will be called with questions. If approved the form will be faxed back to this fax number. If denied, the denial letter will be faxed to this number and mailed to the "requesting physician" in Section IV.

Section II.
Urgent reviews: Request an urgent review to authorize OUTPATIENT treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an urgent review, to prevent a serious deterioration of the patient's condition or health. An urgent review can also be requested for transfer requests from Inpatient acute care stays to LTAC/SNF/SAR facilities. STAT requests can be emailed to mcacaremgmt@abs-tpa.com

Section III.
Extension/Renewal/Reconsideration/Amendment of Previously requested authorizations. Please circle the correct answer or "X" out all but the desired option. Please fill out the reason this change is requested. Example: "Facility Change"

Section IV.

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same." Without this information filled out in it's entirety, the request cannot be processed. NPI number is mandatory.

Section VI.

- Attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.) THIS IS REQUIRED. Requests will not be reviewed without this information.
- Use this space for any additional info you feel is relevant to the request. (Not required.)

Section VII.

- If the nurse reviewer has questions or needs additional information, it may be listed here. Please respond with request information for your request to be processed.
- Approval info will be faxed back in this area. Denials will receive a denial letter faxed and in the US Mail.

If you have questions about what services require authorization please call the number on the back of the member's ID card.