Standardized Prior Authorization Request Form

Please complete all information below. Incomplete submissions may be returned unprocessed.

Please direct any questions regarding this form to HPI.
The Standardized Prior Authorization Form is not intended to replace payer-specific prior authorization procedures, policies and documentation requirements. For payer-specific policies, please reference the payer-specific websites.

Health Plan:	Health Plan Fax#:	*Date Form Completed and Faxed:
HPI	508-756-1382	

Service Type Requiring Authorization [1,2,3] *(check all that apply)*

Oncology
☐Radiation, IMRT or other
☐Infusion or Oncology Drugs (Complete additional form for Chemotherapy)
*See additional form for list of support drugs that do not require prior authorization

Behavioral Health
☐Inpatient
☐CBAT/IBAT/Residential Treatment
☐Partial Hospitalization Program (PHP)
☐Intensive Outpatient Program (IOP)
☐Applied Behavioral Analysis (ABA)

Durable Medical Equipment
☐Purchase over $1,000
☐Purchase under $1,000
☐Rental supplies for more than 3 months
☐Rental supplies for less than 3 months

Home Health/Hospice
☐Home Health *(please indicate:)*
☐SN ☐OT ☐HHA
☐PT ☐ST ☐MSW

☐Hospice
☐Infusion Therapy
☐Respite Care
☐Formula, Enteral/Parenteral nutrition*
**Complete additional form for formula*

Medication
Buy and bill or submit via the **Medical** benefit: ☐Yes ☐No
Cost per dose is **Greater than $2,000:** ☐Yes ☐No

Genetic Testing
☐Total cost over $1,000
☐Total cost under $1,000

Inpatient Care/Observation
☐Acute Medical/Surgical
☐Long-Term Acute Care
☐Acute Rehab
☐Skilled Nursing Facility
☐Observation

Outpatient Surgery/Procedures
☐ Dental anesthesia or procedure
☐ Infertility services*
**Complete additional form for Infertility*
☐Outpatient surgery

Imaging
☐Non-Urgent
☐Urgent/Emergent*

**Precert required for claim payment, clinical not required. Must submit form within 2 business days of the urgent imaging service.*

Provider Information

**Required field*

*Provider Name/Address: ☐*Referring Provider* ☐*Treating Provider*	*Tax ID#:	*Phone#:	*Fax#:
*Servicing Facility Name/Address:	*Tax ID#:	*Phone#:	*Fax#:

*Contact Person:	*Phone#:	Email/Fax#:

Member Information

**Required field*

*Patient Name:	*Insurance Plan Member ID#:	*Gender: ☐ Male ☐ Female	*Date of Birth:

Address:	Phone#:

If other insurance: Insurance Company:	Policy#:

Diagnosis/Planned Procedure Information

**Required field*

*Procedure/Service Description:	*Diagnosis Description:
CPT/HCPCS Codes:	ICD-10 Codes:

Quantity Requested: ☐Hours ☐Days ☐Months ☐Visits ☐Dosage

*Service Start Date:	Surgery Date *(if applicable)*:	*Service End Date:

[1] Please attach plan specific templates that are required for supporting clinical documentation.
[2] Not all services listed will be covered by the benefits in a member's health plan product.
[3] This form does not replace payer-specific prior authorization requirements.