Authorization Request Form Attn: Intake Processing Unit
Phone: 1-844-857-1601 Fax: 1-800-413-8347
Email: auths@dignityhmo.com

Date Request Submitted: ____________

Authorization Type: (Choose appropriate option)

_______**Standard** For request not requiring prioritization (decision made as soon as possible but no later than 14 days) Check here for RETRO request ________

_______**Urgent/Expedited** Request will be reviewed promptly. Request is medically urgent and delay of more than three days could put the member's life, health or ability to regain maximum function in serious jeopardy, and the MD/NP believes the request should be expedited.

_______***Recertification Request*** **Check here if request is in response to a denied claim* ______

Member Name: ________________________________ Member ID:_______________ Date of Birth:_________

Prescribing provider:________________________ Prescribing NPI:______________________
Servicing Provider/Facility: ______________________ Service Provider/Facility NPI:________________
Phone:______________________Fax: ____________________ Email:______________________________

Please reach out to the Dignity Member's dedicated case manager to insure care coordination.

Request Service: ◯ **Inpatient** ◯ **Outpatient** **Is this a scheduled service?** _________________
Dates of Inpatient Admission: ___________________ **Estimated Length of Stay:**___________________
Scheduled or anticipated date of Outpatient services:____

☐ Acute Inpatient Hospital ☐ Skilled Nursing ☐ Psychiatric Inpatient ☐ Inpatient Rehab

____ **Physical Therapy** ____ **Occupational Therapy** ____ **Speech Therapy**
____ **Home Health** ____ **Durable Medical Equipment** ____ **Diagnostic Services**
____ **Specialty Visit** ____ **Part B Medication Request** ____ **Ambulatory/Outpatient Surgery**
____ **Other** ____ ____ **Outpatient Procedure/Service**

_____**Out of Network Inpatient or Outpatient Services**

Notes:____
____
Diagnosis Descriptions: ____
ICD :____
Service Code (CPT, HCPCS, etc) ____
Service Descriptions: ____

Quantity/Frequency/Duration (as applicable): ____
Recertification Request only*; Previously approved dates of services:*________________________
Member Actively Participating? *Functional Progress Made?* *Demonstrates Potential to Improve?*

______**Clinicals are attached to support request (all applicable clinicals should be attached) Signed physician order and clinical notes, including a diagnosis that supports your request, are required for all services.**

For Questions regarding this request, contact:
Name: ____

Phone:________________________Fax: __________________ Email: _______________________________

***Has the Dignity NP or Dignity Case Manager been contacted for care coordination? ______Yes ______ No

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

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