DIGNITY HEALTH PLAN

Authorization Request Form
Attn: Intake Processing Unit
Fax: 1-888-979-8124

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.