REQUEST FOR PRIOR AUTHORIZATION

Date of Request* ☐☐ / ☐☐ / ☐☐☐☐

*Required items. Please write only in designated areas.

Member Information

Member ID*

Date of Birth* __ / __ / ____

Last Name

First Name

Provider to Perform the Service

NPI*

TPI*

Tax ID*

Last Name, First Initial or Facility Name

Fax Number*

Contact Number*

Contact Name / Requestor

Submitting / Referring / Performing Provider

☐ 'X' in box if same as above.

NPI*

Tax ID*

Last Name, First Initial or Facility Name

Fax Number*

Contact Number*

Contact Name / Requestor

Requested Service

Type of Service

☐ DME Rental* ☐ DME Purchase* ☐ DME Incontinence Supply*

☐ Home Health ☐ SNV ☐ PDN ☐ Therapy

☐ Genetic Testing Type:__________ Pregnant ☐ Yes ☐ No

☐ Outpatient Services ☐ Office Visit

☐ Rehab ☐ Evaluations ☐ Re-Evaluations

☐ Inpatient

☐ Other ________________

LTSS Services

☐ PAS

☐ DAHS

☐ ERS

☐ Home Delivered Meals

☐ Med Box Refills

☐ Other ______________

Place of Service*

☐ Office

☐ Outpatient Hospital / ASC Gen

☐ Home

☐ Outpatient Clinic

☐ Outpatient Rehab

☐ Inpatient

☐ Other____________

*All DME require signed physician orders. All HH and Rehab requests require signed physician's order and plan of care/treatment plan.

Clinical Review

Procedure Codes

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Diagnosos

Referring Diagnosis Code*

Referring Diagnosis Code

☐ 'X' indicates clinicals or plan of care

Service Description

__ / __ / ____ Start date*

__ / __ / ____ End date*

Units / Visits* X ☐ Day ☐ Week ☐ Month

Contact Information

Fax Numbers:

LTSS Bexar: 866-224-8254
LTSS Nueces: 866-703-0903
Admissions: 888-886-0170
Referrals: 800-690-7030
Hotline: 800-218-7508

☐ Urgent Request - By checking this box, I certify that this is an urgent request medically necessary treatment, which must be treated within 24 hours.

____
Signature of Requesting Physician *(required)*

Superior requires services be approved before the service is rendered. Please refer to the SHP website, www.SuperiorHealthPlan.com for the most current full listing of authorized procedures and services. Note that an authorization is not a guarantee of payment and is subject to utilization management review, benefits and eligibility.

For Office Use Only

Authorization Number:

Units: ____________________

Dates Authorization: ____________