# Prior Authorization

## Prior Authorization is required for the following covered services

2018 Kalos Health Gold Plus
Authorization by Service Level

- **Durable Medical Equipment and Related Supplies**
- **Inpatient Hospital Care**
- **Inpatient Mental Health Care**
- **Outpatient High Tech Radiological Diagnostic Services**
  Includes MRI, MRA, PET, CTA, CT and SPET Scans
- **Outpatient Surgeries**
- **Prosthetic Devices and Related Supplies**
- **Skilled Nursing Facility (SNF) Care**
- **Inpatient Rehab Admissions**

Services must be provided according to the Medicare Guidelines and limitations and are subject to review.

All medical care, services, supplies and equipment must be medically necessary.

Authorization forms and supporting documentation should be faxed to 800-413-8347 with all necessary and proper information to support the request for services and medical necessity.

**Authorization Request Form Attn:**
**Intake Processing Unit**
**Phone: 1-844-857-1601**
**Fax: 1-800-413-8347**

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.

Authorization Type: (check one) _____ Standard _____ Urgent / Expedited

Date: ____/____/____ *Check here if request is in response to a denied claim* _____

Member Name: _____

Member Number: _____ Date of Birth: ____/____/____

Prescribing Provider: _____

Servicing Provider/Facility Name: _____

Phone: _____ Fax: _____

**Request Service: Inpatient Admissions** **Service Dates:** _____

_____ Acute Inpatient Hospital Admission

_____ Psychiatric Inpatient Admission

_____ Skilled Nursing Admission

_____ Inpatient Rehab Admission

**Request Service: Outpatient Services** **Service Dates:** _____

_____ Physical Therapy

_____ Durable Medical Equipment

_____ Occupational Therapy

_____ Ambulatory / Outpatient Surgery

_____ Speech Therapy

_____ Home Health

_____ Diagnostic Services

_____ Radiology Services

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

ICD_____ Diagnosis Descriptions _____

Service Code (CPT,HCPCS,etc.) _____ Service Descr._____

Quantity/Frequency/Duration (as applicable): _____

**____ Clinicals are attached to support request. (All applicable clinicals should be attached.)**

For Questions Regarding this Request, Contact:

Name: _____

Phone: _____ Fax: _____