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 (required for billed charges in excess of $500.00)**
- **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**
- **Home Health Services Includes Physical Therapy, Occupational Therapy, Speech Therapy, and Skilled Nursing**
- **Inpatient Rehab Admissions**

Services must be provided according to the Medicare Coverage 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:

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