



## **Request for Prior Authorization**

Prior Authorization is required for the following covered services:

- Durable Medical Equipment
- Medical supplies
- Dental procedures outside routine exams and hygiene
- Respite services
- Long-Term Care needs
- Meals
- Day programs
- Home modifications
- Non-urgent transportation
- Skilled Services: Physical, Occupational, Speech or Nursing
- Vision outside routine exams: frames and lenses
- Aide services (PCA; CDPAS)
- Audiology: hearing aides
- Podiatry services

Authorizations for co-payments are NOT required

An authorization is NOT a guarantee of payment.

Any services rendered beyond those authorized or outside approval dates may be subject to denial.



### MLTC Prior Authorization Form

Call: 1-800-894-2464

FAX 716-731-2013

Secure e-mail:

[Kh\\_service\\_authrequest@kaloshealth.org](mailto:Kh_service_authrequest@kaloshealth.org)

Date of Request: \_\_\_\_\_

Authorization Type: (check one): \_\_\_\_\_ Standard \_\_\_\_\_ Urgent / Expedited

#### MEMBER INFORMATION

Name: \_\_\_\_\_ Kalos ID Number: **FCH** \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Insurance: \_\_\_\_\_

#### SERVICING PROVIDER INFORMATION

Prescribing Provider: \_\_\_\_\_

Servicing Provider/Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

National Provider Identification (NPI): \_\_\_\_\_

#### REFERRAL / AUTHORIZATION INFORMATION

Check Services Requested:

<input type="checkbox"/>	Audiology	<input type="checkbox"/>	Consumer Directed Aide	<input type="checkbox"/>	Durable Medical Equipment
<input type="checkbox"/>	Dental	<input type="checkbox"/>	Personal Care Aide	<input type="checkbox"/>	Medical Supplies
<input type="checkbox"/>	Vision	<input type="checkbox"/>	Social Day	<input type="checkbox"/>	Meals
<input type="checkbox"/>	Podiatry	<input type="checkbox"/>	Medical Day	<input type="checkbox"/>	Non-Urgent Transportation
<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Nursing Services	<input type="checkbox"/>	Home Modifications
<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	Long Term Care	<input type="checkbox"/>	Out of Network Provider
<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	Respite	<input type="checkbox"/>	

Service Code (CPT, HCPS, etc.) \_\_\_\_\_ Description of Service \_\_\_\_\_

Quantity/Frequency/Duration (as applicable): \_\_\_\_\_

Clinicals Attached to support request. (All applicable clinicals are attached)  Yes  No

For questions regarding this request, Contact;

Name: \_\_\_\_\_ Phone: \_\_\_\_\_