Kalos Health

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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

Date of Request: 02/05/19

Authorization Type: (check one): ☐ **Standard** ☐ **Urgent / Expedited**

MEMBER INFORMATION

Name: _____ **Kalos ID Number:** _____

Date of Birth: _____ **Primary Insurance:** _____

SERVICING PROVIDER INFROMATION

Prescribing Provider: _____

Servicing Provider/Facility Name: _____

Phone: _____ **Fax:** _____

National Provider Identification (NPI): _____

RERFERRAL / AUTHORIZATION INFORMATION

Check Services Requested:

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

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:** _____

Submit Form (Works with IE and Adobe, but might not work in other browsers)