Prior Authorization

2019 Kalos Health Gold Plus (HMO-SNP) Authorization by Service Level

Prior Authorization is required for the following covered services

- **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	☐	Diagnostic Services	☐	Durable Medical Equipment
☐	Occupational Therapy	☐	Ambulatory / Outpatient Surgery	☐	Home Health
☐	Speech Therapy	☐	Radiology Services	☐	Out of Network or Outpatient Svcs.

ICD _____ Diagnosis Descriptions _____

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: _____