

# Prior Authorization

## 2020 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

Email: nyauths@accesshealth.services

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: \_\_\_\_\_

<input type="checkbox"/>	Acute Inpatient Hospital Admission	<input type="checkbox"/>	Psychiatric Inpatient Admission
<input type="checkbox"/>	Skilled Nursing Admission	<input type="checkbox"/>	Inpatient Rehab Admission

Request Service: Outpatient Services Service Dates: \_\_\_\_\_

<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Diagnostic Services	<input type="checkbox"/>	Durable Medical Equipment
<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	Ambulatory / Outpatient Surgery	<input type="checkbox"/>	Home Health
<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	Radiology Services	<input type="checkbox"/>	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: \_\_\_\_\_