



**GOLD KIDNEY HEALTH PLAN**

## **Pre-Authorization Request Form**

**Fax to: 1-866-515-7869**

**Used for skilled nursing, long term acute care, inpatient rehabilitation, inpatient and outpatient surgeries, outpatient medical services, transplants, DME and professional services.**

**Instructions:** This form should be filled out by the provider requesting the service or DME. Please complete all applicable fields. Prior to completing this form, please confirm the patient's benefits, eligibility and if pre-authorization is required for the service. **Healthcare providers who participate in an independent practice association (IPA) or other risk network with delegated services are subject to the prior authorization list and should refer to their IPA or risk network for guidance on processing their request.**

Have you verified if pre-authorization is required? ☐ Yes ☐ No

**Only select services require prior authorization. Contact Provider Services at 1-844-294-6535**

**\*Note: If no, please verify with the pre-authorization list on the Provider Web site or call the number on the back of the member's card.**

Is this request: ☐ New ☐ Authorization Extension ☐ Providing Additional Information ☐ Check for Authorization Status

If you already have an authorization number, please list it here \_\_\_\_\_

### **SECTION 1- PATIENT INFORMATION:**

|                                                                                                                                                                                     |               |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Patient Name (Last):                                                                                                                                                                | First:        | MI | Patient's Phone Number      |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Member ID Number:                                                                                                                                                                   | Group Number: |    | Date of Birth: (mm/dd/yyyy) |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|                                                                                                                                                                                     |               |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

### **SECTION 2- PROVIDER INFORMATION**

|                                                                                                                                                  |                            |                |            |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------|------------|
| Please check one: <input type="checkbox"/> Requesting Provider <input type="checkbox"/> Rendering Provider <input type="checkbox"/> DME Supplier |                            |                |            |
| Provider Name:                                                                                                                                   |                            | Tax ID Number: |            |
| NPI                                                                                                                                              | Phone Number               |                | Fax Number |
| Provider Address                                                                                                                                 | City                       | State          | ZIP Code   |
| Who should we contact if we require additional information?                                                                                      |                            |                |            |
| Name                                                                                                                                             | Phone Number (include ext) | Fax Number     |            |

| SECTION 3- PREAUTHORIZATION REQUEST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                            |                                                                                                |       |          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------|------------------------------------------------------------------------------------------------|-------|----------|
| Is this request: <input type="checkbox"/> Pre-Service or <input type="checkbox"/> Concurrent Review <input type="checkbox"/> Date of Service (if scheduled) _____ (mm/dd/yyyy)<br>Please check one: <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ASC <input type="checkbox"/> Office <input type="checkbox"/> Other<br>Please check all that apply: <input type="checkbox"/> Surgical <input type="checkbox"/> DME <input type="checkbox"/> Diagnostic <input type="checkbox"/> Medical <input type="checkbox"/> Other |  |                            |                                                                                                |       |          |
| Rendering or Treating Provider and Provider Specialty                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                            | Tax ID Number                                                                                  |       | NPI      |
| Physical Address where services will occur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                            | City                                                                                           | State | ZIP Code |
| Phone Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                            | Fax Number                                                                                     |       |          |
| IF INPATIENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                            | IF DME                                                                                         |       |          |
| Facility Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                            | Company Name                                                                                   |       |          |
| Tax ID Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | NPI                        | Tax ID Number                                                                                  |       | NPI      |
| Anticipated Admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Anticipated Length of Stay | DME Address                                                                                    |       |          |
| Phone Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Fax Number                 | City State ZIP Code                                                                            |       |          |
| <b>Note:</b> If anticipated length of stay is not indicated, no more than two days will be assigned if approved.<br><b>Note:</b> This form does not serve as a notification of admission. Please reference the Provider Web site for instructions to notify us of admission.                                                                                                                                                                                                                                                                                                       |  |                            | Signed copy of Prescription attached: <input type="checkbox"/> Yes <input type="checkbox"/> No |       |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                            | Invoice attached: <input type="checkbox"/> Yes <input type="checkbox"/> No                     |       |          |
| <b>If this is an expedited request and meets the definition indicated below, please check the expedited request box <input type="checkbox"/></b><br><b>Expedited is defined as:</b> when the Member or his/her physician believes that waiting for a decision under the standard time frame could place the Member's life, health, or ability to regain maximum function in serious jeopardy.<br><b>Note:</b> If more codes are requested they can be added in here or a separate document may be attached.                                                                        |  |                            |                                                                                                |       |          |
| <b>Please provide all diagnosis, CPT® or HCPCS codes and their descriptions, if available; this will help processing of your request.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                            |                                                                                                |       |          |
| Diagnosis code(s) and description(s):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                            | CPT® or HCPCS code(s) and description(s):                                                      |       |          |
| Primary:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                            |                                                                                                |       |          |
| Second:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                            |                                                                                                |       |          |
| Third:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                            |                                                                                                |       |          |

**Please submit the following clinical information with this form as appropriate for this request:**

- ♦ History & Physical
  - ♦ Lab/Radiology/Testing Results
  - ♦ Current Symptoms & Functional Impairments
  - ♦ Treatment History
- and any other information such as chart notes that support medical necessity for the request.