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 medicalservices, 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)

SECTION 2- PROVIDER INFORMATION

Please check one: ☐ Requesting Provider ☐ Rendering Provider ☐ 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 aditional information?			
Name	Phone Number (include ext)	Fax Number	

SECTION 3- PREAUTHORIZATION REQUEST

Is this request: ☐ Pre-Service or ☐ Concurrent Review ☐ Date of Service (if scheduled) _____ (mm/dd/yyyy)
Please check one: ☐ Outpatient Hospital ☐ Inpatient ☐ ASC ☐ Office ☐ Other
Please check all that apply: ☐ Surgical ☐ DME ☐ Diagnostic ☐ Medical ☐ 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	

Note: If anticipated length of stay is not indicated, no more than two days will be assigned if approved.
Note: 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: ☐ Yes ☐ No

Invoice attached: ☐ Yes ☐ No

If this is an expedited request and meets the definition indicated below, please check the expedited request box ☐
Expedited is defined as: when the Member or his/her physician believes that waiting for a decision under the standard time framecould place the Member's life, health, or ability to regain maximum function in serious jeopardy.
Note: If more codes are requested they can be added in here or a separate document may be attached.

Please provide all diagnosis, CPT® or HCPCS codes and their descriptions, if available; this will help processing of your request.

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.