VNS Health

Pre-Authorization Request Form

Date Form Completed and Faxed: _____

Please complete this form and fax it to the plan number on the back to request pre-authorization.

Health Plan: ☐ VNS Health EasyCare (HMO) ☐ VNS Health EasyCare Plus (HMO D-SNP) ☐ VNS Health Total (HMO D-SNP) ☐ Managed Long Term Care (MLTC) ☐ SelectHealth from VNS Health	**Type of Request** (check as applicable): ☐ New request ☐ Expedited review (member faces imminent and serious threat to life or health- requires supporting clinical evidence) ☐ Written confirmation of prior oral request
Member Information	
Name (last, first):	Other insurance:
Date of birth:	Other insurance policy number:
Member ID#:	Other insurance policy holder:
Sex (circle one):☐M or☐F	Gender Identity:
PCP Name:	
Provider Information	
Requesting provider	**Servicing provider**
Name:	Name:
Address:	Address:
Tel:	Tel:
Fax:	Fax:
Contact Person:	Specialty:
NPI:	NPI:
Required Clinical Information	
Diagnosis (list codes & description)	
1.	3.
2.	4.
Procedure/service requested (list all CPT/HCPCS Codes & descriptions)	
1.	4.
2.	5.
3.	6.

For Facility Admissions only:	
Admission Type: ☐ Emergency: _____ Admin date ☐ Elective: _____ Anticipated admit date	Facility Type: ☐ Acute Care Hospital Long Term Acute Care ☐ Acute Rehab Facility/unit ☐ Skilled Nursing Facility
Facility Name:	Facility Phone:
Facility Fax:	Facility Address:
For Home Health only:	
Personal Care Services: ☐ New Request ☐ Resumption of Care ☐ Request for Increase ☐ Existing service – hours/days per week Hours per day _____ Days per week _____	Home Care Services: ☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Language Pathology Number of visits _____
Service start date: _____ Service end date: _____ (If applicable)	Date of request: _____
For Outpatient Services only:	
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Language Pathology ☐ Genetic Testing	☐ Radiation Therapy ☐ Radiology Services ☐ Other Service _____
Required Documentation	
Please attach supporting clinical information. Requests received without supporting clinical notes and required codes will not be reviewed. If this is a request for therapy, please use a separate form for each service.	

Please note the following definitions and timeframes for processing requests:

Definitions:

Expedited – member faces imminent and serious threat to life or health; requires supporting clinical evidence. Requests are reviewed to ensure they meet the criteria to be expedited. If they do not meet the criteria, the request will be processed within the standard timeframe.

Standard – all requests not meeting the expedited criteria.

Timeframes:

VNS Health Medicare:

- **Professional services/DME**: Expedited – 72 hours, Standard – 14 calendar days
- **Medicare Part B drug coverage:** Expedited – 24 hours, Standard – 72 hours

MLTC: Expedited – 72 hours, Standard – 14 calendar day

SelectHealth: Expedited – 72 hours, Standard – 14 calendar days

- Once clinical information is received, the plan must make a decision within 3 business days for standard prior authorizations, and within 1 business day for standard concurrent or expedited authorizations.

Please also note that when a member has a primary insurance (such as Medicare) and either MLTC or SelectHealth as the last payor, a proper denial or explanation of benefits must be obtained before an item can be balance billed.

Fax completed form and supporting documents to plan specific fax number below:
Medicare: 866-791-2214 MLTC: 212-897-9448 SelectHealth: 646-459-7731

For questions about your request or any claims you submitted, please call 1-866-783-0222,
Monday – Friday, 8 am – 5 pm.