



SWHP Authorization Request Form

*****When completed with original signature, fax to SWHP HSD at: 1-800-626-3042 or 254-298-3450*****

(1) From Physician _____ (please print)	(2) Physician NPI # _____	(6) Request Status(based only on medical status) <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent <input type="checkbox"/> Routine <input type="checkbox"/> Elective/Pre-Auth <input type="checkbox"/> Retrospective
		TYPE <input type="checkbox"/> Inpatient (Plan) <input type="checkbox"/> Inpatient (Actual) <input type="checkbox"/> Outpatient <input type="checkbox"/> 23hr.Observation
(3) Phone _____	(4) Fax _____	
(5) Office Contact Person/Phone# _____		

(7) To: Phys/Prov. _____ Service Address _____ City/State/ZipCode _____ Phone _____ Fax _____	(11) Patient Name _____ (12) Member Number _____ (13) DOB _____ MRN: _____ Phone _____ (14) Diagnoses _____ (15) ICD-9 Codes _____ (16) Procedure(s) _____ (17) CPT Code(s) _____
(8) Date of Referral _____	(9) Appt. Date _____ (if known)
(10) # Requested Visits ___ over _____ (wks/mos.)*	

(*Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent.) **Note: While ICD-9 and CPT Codes are not mandatory (only text of diagnoses and procedures), the actual codes that will be billed assists SWHP in more efficiently processing the requested services for a coverage determination in a timely manner to assist you later in prompt payment of any authorized services.**

(18) Referral Requested by: Physician/Provider Member/Patient Other _____

(19) Service Request is for: Initial Consult F/U to Consult Visit 2nd Opinion Outpt. Visit Only (no tests/procedures)
 2nd Opinion Outpt. Visit (to include testing/procedure: _____) Evaluate & Assume Care
 Procedure Only Procedure & F/U Visit
 Other: _____

(20) Indication(s)/Justification* [Note: *Attach any pertinent information to assist SWHP in timely processing of the request. If requesting out-of-network services, justification for out-of-network referral, indicating the reason in-network service is not available/appropriate, is required in addition to the clinical indication for the service. Services are subject to coverage, benefit, network, and contract policies and exclusions.]

(21) _____ Signature of Referring M.D. **(no stamped signatures accepted)**

Note: Members may be financially responsible for services they schedule themselves without a referral (if referral is required by their Evidence of Coverage/Standard Plan Document). Members also will be financially responsible if they receive non-covered benefits without required Plan pre-authorization. All services for tertiary and non-contracted providers or facilities must be prior authorized by SWHP.

(22) SERVICE(S) NOT COVERED or REQUIRES PRIOR APPROVAL (May request written criteria to review)

Coronary CT Angiography _____

Spine Surgeries (Specify) _____

Major Joint Replacement(s) (Specify) _____

Plastic Surgery _____

Dental/Oral Surgery _____

Home Infusion Services _____

Nursing Home or Home Health Physical/Occupation/Speech Therapy
 Provider _____ Phone# _____
 Modality _____ Frequency _____ Duration _____

Skilled Nursing Facility Care at _____
 Reason _____
 Duration _____

Inpatient Rehab at _____
 Reason _____
 Duration _____

Long-Term Acute Care at _____
 Reason _____
 Duration _____

Any Out-of-Network Services _____

Other or Additional Comments _____

- 1 **From Physician** - Physician who is requesting SWHP coverage of a service and/or providing a required notification.
- 2 **Physician Number** – National Provider Identification number assigned to participating physician.
- 3 **Phone** - Requesting physician's phone number for Plan to reach them on a routine basis.
- 4 **Fax** - Facsimile (FAX) phone number to physician's office to return and/or request required information as needed.
- 5 **Office Contact Person/Phone#** - Referral Clerk and/or Office personnel that is facilitating request on behalf of the physician/provider
- 6 **Request Status/Type** – the **medical urgency** of request; **not** based upon scheduling/appointment access, unless underlying medical status warrants such **AND/OR** identifies the type of level of request, such as Inpatient-planned vs. actual; Observation levels of coverage request
- 7 **To: Physician/Clinic plus Address** – name of physician, health care provider, hospital or clinic facility to which the referral or request is being directed (to include all identifying information of address, phone, and fax numbers for that entity-**required to process request**).
- 8 **Date of Referral** – actual date request or referral has been made by the requesting physician.
- 9 **Appointment Date (if known)** – date services are scheduled to occur if already arranged by the requesting physician's office.
- 10 **# Requested visits/over time period** – actual number of visits and the end date (or time period) by which these physician-requested services are to be completed. **(Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent.)** Note: While ICD-9 and CPT Codes are not mandatory (only text of diagnoses and procedures), the actual codes that will be billed assist SWHP in more efficiently processing the requested services for a coverage determination in a timely manner to assist you later in prompt payment of any authorized services.
- 11 **Patient Name** – Actual Member's name that is to receive the services
- 12 **Member #** - Member's SWHP membership number
- 13 **DOB; MRN; Phone** – Date of Birth of the Member/Patient to receive the services; medical record #, if known; current working phone # for Member
- 14 **Diagnosis/Diagnoses** – Member's principle diagnosis as the reason for consult/procedure notification and/or request for prior approval of a service. (May include secondary diagnoses as appropriate.)
- 15 **ICD-9 Codes** – Corresponding Codes to Diagnosis or Diagnoses listed in #14 **(Note: These are not required but assist SWHP in more timely processing of your request and response if you are willing to provide them.)**
- 16 **Procedure(s)** – Actual tests and/or procedures requested to be performed
- 17 **CPT Codes** – Corresponding codes to the conditions listed in #16. **(Note: These are not required but assist SWHP in more timely processing of your request and response if you are willing to provide them.)**
- 18 **Referral Requested by** – Identifies the individual requesting the referral authorization (i.e., is the physician/provider requesting this service or facilitating a Member/Patient personal request OR is there some other source, such as another consultant, making the request)
- 19 **Service Request is:**
- A **Initial Consult-** Physician visit (one) for initial new patient to evaluate and make recommendations to the requesting provider **(Note: Additional, out-of-network services individually require prior authorization from SWHP to pay and must be requested/outlined separately within this request form.)**
 - B **F/U to Consult-** Physician visit (one) as an established patient to review findings of the initial consultation and to make recommendations to the Member/referring physician
 - C **2nd Opinion Outpatient Visit Only (No tests/procedures)** One outpatient full 2nd Opinion Visit with Member taking all medical records, labs, tests, reports of scans, invasive procedures, etc. for the visit. No additional services are being requested by the referring physician to be provided by the consulting physician to render the 2nd Opinion.
 - D **2nd Opinion Outpatient Visit (to Include Tests/Procedures)** One outpatient full 2nd Opinion Visit with Member taking all medical records, labs, tests, reports of scans, invasive procedures, etc. for the visit; however, with the understanding that additional testing/procedures may be performed to render the 2nd Opinion **(Note: If choosing this option, must list on form any/all anticipated tests/procedures/labs that may be performed and should be considered in this review process.)**
 - E **Evaluate & Assume Care** – Physician visit for either initial (new) patient visit or follow-up (established) patient visit, but PCP requests that the consulting physician can perform or request approval from the Plan for care/treatment related to the referral diagnosis for the Plan-authorized effective dates (usually 3-6 months, unless otherwise noted). **[This does NOT mean “assume role as a primary physician”].**
 - F **Procedure Only** – Physician visit with the requested specialist and/or the Plan-approved procedure, to include medically necessary lab/x-ray as outlined under “initial/f/u consult” category.
 - G **Procedure & F/U Visit** – acknowledges that the referral/consulting physician performing a procedure will need to do a f/u visit, as opposed to the referring PCP or Specialist
- 20 **Indication(s)/Justification** - Physician's documentation of the medical necessity of the requested service **(may submit any pertinent information as an attachment faxed with this request form).** **(Note: clear and complete justification is required for any out-of-network request to prevent an inadvertent denial &/or delay to recontact provider for the information before the request can be processed.** Services are subject to coverage, benefit, network, and contract policies and exclusions.)
- 21 **Signature of Referring M.D.** – **ORIGINAL SIGNATURE of SWHP-Contracted Physician REQUIRED/No stamps or “initialed” signatures will be accepted.**
- 22 **Services Requiring Prior Approval** - care/treatment that requires authorization from the SWHP Health Services Division for a coverage determination **before services are rendered.** Services are subject to coverage, benefit, network, and contract policies and exclusions.]