CARE to CARE
MULTI-SPECIALTY MANAGEMENT

Imaging Excellence Program

Authorization Request Form

Fax this request form to 1-888-248-4884

(Please print clearly)

elderplan homefirst®

STOP **Please consider using the web to submit your requests. To submit online, visit: https://elderplan.careportal.com.**

****If Urgent Please Call**

Referring Provider Information					
#1 **Date request submitted:**	MM/ DD/ YYYY	#2 **Office contact person:**			
#3 **Provider Name:**		#4 **Physician Specialty:**			
#5 **Physician ID (NPI):**		#6 **Phone:** (XXX) XXX - XXXX		#7 **Fax:** (XXX) XXX - XXXX	
#8 **E-mail Address:**					

Rendering Facility/Practice Information					
#9 **Facility/Practice Name:**		#10 **Facility/Practice Address:**			
#11 **Phone:** (XXX) XXX - XXXX		#12 **Fax:** (XXX) XXX - XXXX		#13 **Facility/Practice NPI#:**	
#14 **Member name:**		#15 **Date of Birth:**	MM/ DD/ YYYY		
#16 **Member ID#:**		#17 **Member Phone #:**	(XXX) XXX - XXXX		
#18 **Program: (check one)**	☐ **HMO** ☐ **SNP** ☐ **FIDA**				

List procedure(s) Ordered

#19 **Procedures**	#20 **CPT code**	#21 **Modifier**	#22 **Units**

#23 **Clinical indications for the ordered exams (e.g., signs, symptoms with severity and duration, working diagnosis)**	
THIS SECTION MAY BE ACCOMPANIED OR REPLACED BY A COPY OF MEDICAL NOTES AND/OR REPORTS OF RELEVANT IMAGING AND LAB STUDIES SUPPORTING THE MEDICAL NECESSITY FOR THE STUDY REQUESTED.	#24 **Primary ICD-10 Code**

Any relevant prior tests, treatments or other information

If our Physician Reviewer needs to contact the ordering provider, what is the best day, time and phone number?					
#25 **Days** (circle):	M T W Th F	#26 **Times:**		#27 **Phone:**	(XXX) XXX - XXXX
#28 **Requested by (print):**				#29 **Submission Date:**	MM/ DD/ YYYY

#30 **Referring Provider Signature:**

Think GREEN **Please use the web for your requests. To submit online, visit: https://elderplan.careportal.com.**

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Instructions for Filling out Form Fields of Required Information

Field No.	Name	**Description** – Below contains a brief description. For more detailed information see Provider Manual.
1.	*Date Request Submitted*	Date the Request form is being submitted **–** **MM/DD/YYYY**
2.	*Office Contact Person*	Person filling Prior Authorization Request Form or Name of Best Contact Person
3.	*Provider Name*	Referring/Ordering Provider's **First & Last Name**
4.	*Physician Specialty*	Referring/Ordering Provider's Specialty
5.	*Physician ID (NPI)*	Referring/Ordering Provider's NPI # - **Mandatory**
6.	*Phone*	Referring/Ordering Provider's Office Phone # **-** **1 (XXX) XXX-XXXX**
7.	*Fax*	Referring/Ordering Provider's Office Fax # **-** **1 (XXX) XXX-XXXX**
8.	*E-Mail Address*	Referring/Ordering Provider's Office E-Mail Address **-** **Mandatory**
9.	*Facility/Practice Name*	Rendering Facility/Practice Name Where Procedure Will Take Place
10.	*Facility/Practice Address*	Rendering Facility/Practice Address Where Procedure Will Take Place
11.	*Phone*	Rendering Facility/Practice Phone # **-** **1 (XXX) XXX-XXXX**
12.	*Fax*	Rendering Facility/Practice Fax # **-** **1 (XXX) XXX-XXXX**
13.	*Facility/Practice NPI #*	Insert Rendering Facility/Practice NPI#
14.	*Member Name*	Name of Member Procedure is Being Requested For
15.	*Date of Birth*	Date of Birth for the Member **–** **MM/DD/YYYY**
16.	*Member ID #*	Medicaid ID # of the Member
17.	*Member Phone #*	Best Contact Phone # for the Member **-** **1 (XXX) XXX-XXXX**
18.	*Program: (check one)*	Program under which Member is covered **(Please select ONE box)**
19.	*Procedures*	Description or Modality of Procedure(s) Being Requested
20.	*CPT Code*	CPT Code Associated with Requested Procedure(s)
21.	*Modifier*	Body Modifier (i.e. Left, Right)
22.	*Units*	Number of Requested Units
23.	*Clinical Indications for the Ordered Exams*	Explained in Description, Option to Fill In Information Fields or Attach Clinical Notes
24.	*Primary ICD-9 Code*	Minimum of 1 Primary Diagnosis/ICD-10 Code Required with Each Requested CPT Code
25.	*Days (Circle)*	Best Day(s) Available to Reach Referring Physician **–** **circle days**
26.	*Times*	Best Time(s) of Day to Reach Referring Physician **–** **(Note Program Open 8am-7pm EST)**
27.	*Phone*	Best Phone # to Reach Referring Physician **- 1 (XXX) XXX-XXXX**
28.	*Requested by (Print)*	Printed Name of Referring/Ordering Provider
29.	*Submission Date*	Date the Prior Authorization Form is Being Submitted
30.	*Signature*	Signature of Ordering Provider

Revised 01/2017

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