Affinity Health Plan

Fax this form to: 718-794-7822

REQUEST FOR PRIOR AUTHORIZATON FORM

Please use appropriate form for Medical Benefit Drug, DME, Prenatal and Outpatient rehabilitation (PT/OT) services. For Transportation contact LogistiCare 866-428-2351; For Radiological Services contact EviCore 866-242-5615; For Dental: 866-731-8004; For Vision: 866-810-3312. Initial determination is based upon national clinical guidelines and internal policies utilized by Affinity Health Plan. If the provider disagrees with determination, additional information can be submitted to substantiate medical necessity of procedure based upon denial rationale or request review by specialist.

This form should be completed and faxed to AFFINITY HEALTH PLAN within 24 hours of an Urgent/Emergent Admission, and no less than 2 weeks prior to a request for an elective service. *This form must be accompanied by all clinical (information) relevant to the service requested. Incomplete requests will delay the authorization process and/or result in an adverse determination.* ***Authorization is pending confirmation of Member eligibility at time of service.*** If approved, authorization for service does not constitute a guarantee of payment by Affinity Health Plan.

Member Name: _____

D.O.B.: ___ /____/_____ Member ID#: _____

Request Date: _____/_____/_____

Contact Person: _____

Contact Phone: _____

Contact Fax: _____

Reason for Request with Clinical Documentation

Tax ID or NPI must be submitted at time of request

Name of Servicing Facility: _____

Servicing Facility NPI #: _____

Referring Provider Name: _____

Referring Provider TIN # _____

Referring Provider NPI # _____

Servicing Provider Name: _____

Servicing Provider TIN # _____

Servicing Provider NPI # _____

Servicing Provider Address:

_____

If Non-Participating Provider please use Out of Network Authorization Request Form

Service Request(s) Please select appropriate service and submit all appropriate codes

	Date of Service	Place of Service	Diagnosis code	Diagnosis description	Procedure code	Procedure description
Elective						
Ambulatory Surgery						
DME						
Home Care						
Transplant						
Non-Emergent Ambulance						
Other						

Please provide Clinical Information (copy of office notes preferred) which includes: Brief medical history, Results of physical exam, Diagnostic Tests/Lab, Functional Problems, Presenting symptoms and Treatment Plan.

Fax this form to: 718-794-7822. If you have any questions regarding this form, please call Affinity's Medical Management Department at 1-866-247-5678 between the hours of 8:30 am to 5:00 pm Monday – Friday.