



Fax this form to: 718-794-7822

REQUEST FOR PRIOR AUTHORIZATION 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.

This information has been disclosed to you from confidential records, which are protected by state law. State law prohibits you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of medical or other information will be in violation of the state law and may result in a fine or jail sentence or both.