Affinity Health Plan

Fax this form to
718.794.7822

REQUEST FOR PRIOR AUTHORIZATION

This form should be completed and faxed to AFFINITY HEALTH PLAN within 24 hours ofan 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 which includes medical history, results of physical exam, diagnostic tests, lab test results, functional problems, presenting symptoms and treatment plan. 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.

Please refer to the provider page at Affinityplan.org for these services: Behavioral Health, Medical Benefit Drug,Transportation, Dental, Vision , Radiology, Outpatient Rehab, Sleep Studies and Cardiac Imaging.

Member Name:_____ D.O.B.: ___ /____ /_____ Member ID #:_____ Medical Record #: _____
(for Inpatients)

Request Date:_____ /_____ /_____ L.O.B.: _____

Contact Person: _____ Contact Phone: _____ Contact Fax:_____

If non-participating provider, please check here ☐ Please state reason for out-of-network service:_____

_____

Negotiator Name: _____ Phone: _____ Fax: _____

Tax ID or NPI must be submitted at time of request.

Name of Servicing Facility: _____ Servicing Facility NPI #: _____

Servicing Provider Name: _____

Servicing Provider TIN #: _____

Servicing Provider NPI #: _____

Referring Provider Name: _____

Referring Provider TIN #: _____

Referring Provider NPI #: _____

If a delay in this review would seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, please check the box ☐. If box is checked, indicating an expedited request, an explanation must be written to explain why and how the Enrollee's life would be adversely affected:_____

_____

Physician Signature:_____ Date:_____ /_____ /_____

Please select appropriate service and submit all appropriate codes.

Place of Service: _____

- ☐ Urgent/Emergent Admission
- ☐ Elective Inpatient Admission
- ☐ Elective Outpatient
- ☐ Ambulatory Surgery
- ☐ Home Care
- ☐ Transplant
- ☐ Durable Medical Equipment (DME)
  - ☐ Rental ☐ Purchase
- ☐ Non-Emergent Ambulance
- ☐ Other (Please specify)
  _____

Service Start Date: _____ Service End Date: _____

Diagnosis Code(s): _____

Procedure Code (Units):_____