Prior Authorization Request Form

To submit requests, please fax completed form to the Utilization Review Department: **202-905-0157 or 202-821-1098**
If you have any questions, you can reach the Utilization Review Department directly:**202-821-1132**

Providers are responsible to obtain prior authorization for services prior to scheduling. Please submit clinical information as needed to support medical necessity of the request. **Requests cannot be processed if missing clinical information or CPT and ICD-10 codes**. As a reminder, authorization is not a guarantee of payment; payment is subject to benefit coverage rules, including member eligibility and any contractual limitations in effect at the time of service.

Today's Date:_____ Requested Date of Service:_____

○	Standard Request	Trusted Health Plan has up to 14 days to render a decision for standard requests.
○	Priority Request	Services are scheduled for the following date:
○	Urgent	Trusted Health Plan, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member.

Physician's Signature:_____ Date signed:_____

MEMBER INFORMATION

Alliance/Medicaid ID Number:	Enrollee Last Name:	Enrollee First Name:

Date of Birth: *I* Gender: ○ Male ○ Female

REVIEW TYPE

○ Initial	○ *Change DOS/Setting	○ *Extension of Services	○ Additional Clinical

○Cancel ○*Other*(specify)* ○ Discharge Planning (Services needed for member discharged from inpatient setting such as hospital, skilled nursing facility, etc.)

*Please Specify *(If applicable, previous authorization number)*_____

Service Type:

○ Orthotics/ Prosthetic ○ Home Care ○ Non-Par ○ Durable Medical Equipment *(DME)* ○ *Other

*Please Specify *(If applicable, previous authorization number)*_____

PROVIDER INFORMATION

Submitting Provider Name:	Contact Name and Phone Number:	Fax Number:
Services Provided by or Facility/Provider ID#	**Contact Name and Phone Number:**	**Fax Number:**

DO NOT WRITE BELOW THIS LINE: FIELDS TO BE COMPLETED BY TRUSTED HP *(Revised December 1,2016)*

Authorization #_____ Trusted Health Plan UM Assistant _____

TRUSTED Health Plan
1100 New Jersey Avenue, S.E., Suite 840, Washington, DC 20003

Utilization Management Contact Information
Phone: **202-821-1132**

Member ID#: _____

Treatment Setting:

○ Outpatient ○ Inpatient ○ Home ○ In-Office ○ Other

*Please specify if other selected: _____

HCPCS/CPT CODES

ICD-10 Code	HCPCS/CPT	Code Description	Dates of Service	
			From	Thru
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I

Other Clinical Information- Include/attach clinical/office notes, labs, imaging reports, etc., to support medical necessity.
If this is an out-of-network request, please provide an explanation.

REHABILITATION SERVICES

Type of Therapy: ○ Speech ○ Physical ○ Occupational ○ *Other

Number of Units/Visits Requested:	Previous Authorization Number:	*Date(s)* Requested:
○ Extension	○ Initial	

Additional Comments:

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Authorization #_____ Trusted Health Plan UM Assistant _____

TRUSTED Health Plan
1100 New Jersey Avenue, S.E.,
Suite 840, Washington, DC 20003

Utilization Management Contact Information
Phone: **202-821- 1132**

Member ID#:_____

HOME CARE

Name of Agency:	Number of Units/ Visits Requested:	Number of Previous Visits:
Previous Authorization Number:	Initial	Extension

Additional Comments:

DURABLE MEDICAL EQUIPMENT

Diagnostic Indication:	Duration and Frequency of Use:	Acute or Chronic condition:
Previous Authorization Number:	Length of time needed:	
Initial	Renewal	
Rental	Purchase	

Additional Comments:

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Authorization #_____ Trusted Health Plan UM Assistant:_____

TRUSTED Health Plan
1100 New Jersey Avenue, S.E.,
Suite 840, Washington, DC 20003

Utilization Management Contact Information
Phone: **202-821-1132**