Saint Mary's Health Plans

A member of CHW

1510 Meadow Wood Lane
Reno, Nevada 89502
(775) 770-6000
www.saintmaryshealthplans.com

NOTE: If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you have received this document in error. If you have received this communication in error, please notify us immediately by telephone at (775) 770-6211.

PRIOR AUTHORIZATION REQUEST

☐ 1st Request ☐ 2nd Request ☐ STAT / Urgent ☐ **HealthFirst** ☐ **Health Choice**

Medical Management • 775-770-6211 • Fax: 775-770-6250 • Date Requested: ____________________

You may request and receive authorization online via the secure provider portal at www.saintmaryshealthplans.com/providers/index.php

Patient Name:		**Requesting Physician Name:**
Patient ID#:		Office Contact Name:
Date of Birth:		Contact Telephone Number:
Primary Care Physician:	PCP Fax:	Contact FAX Number:

Diagnosis and ICD-9 Code:		**Work Related:** ☐ Yes ☐ No
Requested Facility Name / Physician Name:	Date of Service:	Requested LOS:
Requested Procedure Description and CPT Code:	☐ Inpatient ☐ SDS ☐ Outpatient ☐ PT / OT / SP ☐ DME ☐ Home Health / Hospice ☐ Infusion Therapy Surgical Assist Requested: ☐ Yes ☐ No If yes, name:	
COMMENTS: *(ATTACH ALL APPROPRIATE OFFICE RECORDS, LAB, X-RAY, AND PROCEDURE REPORTS)*		

REVIEW / NOTIFICATION COMPLETION TIMES FROM RECEIPT OF REQUEST: Urgent Concurrent – 24 hours; Urgent Preservice – 72 hours; Non-Urgent Preservice – 15 days; Post Service – 30 calendar days. Urgent requests are reserved for emergent situations and not for services or procedures that were scheduled before authorization was obtained.

FOR OFFICE USE

Date / Time Request Received / Initials:		Covered Benefit: ☐ Yes ☐ No COB: ☐ Yes ☐ No
Eligibility Confirmed (Type / Effective Date):		Date Complete Info Received: ☐ Requested Info Not Rec'd
Date(s) Additional Info Requested:		Nurse Review Decision: / Initials: _______ Date: _____________ ☐ Approve ☐ Refer to Medical Director
Nurse's Comments:		
Medical Director Review Decision: ☐ Approve Request ☐ Deny Request		
Reason for Denial Decision: ☐ Non Covered Benefit ☐ Not enough documentation received to approve request		☐ Out of Area – Out of Network – Non Par Provider (not approved because In Network Provider available) ☐ Medical information does not meet specific criteria
COMMENTS:		
Medical Director Signature:		Date:
Authorization # / Reference #:	# Visits:	Initial Authorized Length of Stay: ___________ (applies to inpatient procedures only) From ______/______/______ To ______/______/______

Request for referral does not guarantee authorization. You will receive written notice of the authorization decision by return FAX. Authorization/referrals will be valid for at least 90 days, unless otherwise stated. Authorization is not a guarantee of payment. Non-covered services or services rendered to a patient whose coverage is no longer effective are the patient's responsibility.