# GENERAL AUTHORIZATION REQUEST FORM

**Please fax this form along with supporting clinical documentation to the appropriate fax number below (corresponding to the service type).**

**Please do not use this form for outpatient therapy or home care. Please go to the form download link to retrieve the appropriate forms for these services.**

| | | | |
|---|---|---|---|
| Medicaid/Marketplace Exchange/Essential Plan/CHP/Gold | Fax 212-908-8521/8522 | Medicare | Fax 212-908-4401 |
| Personal Care Services & Adult Day Health Care | Fax 212-908-5237 | SNF/Rehab/LTAC | Fax 212-908-3023 |
| DME Requests submit to Integra (for all LOBs except MLTC) | Fax 212-908-5185 | General Inquiries | Call 800-303-9626 |
| DME Requests for MLTC ONLY (MLTC) | Fax 212-908-5282 | Form Download Link | www.metroplus.org |
| Medicaid J-code (Physician Administered Drug) Requests ONLY | Fax 212-908-5178 | | |

| **Authorization/Tracking #:** | **E-Power Cert #:** (if applicable) |
|---|---|

## REQUEST TYPE

| | | |
|---|---|---|
| ☐ **Preauthorization:** New request for services not previously approved, prior to service date | ☐ **Concurrent:** Request for additional services for a service previously approved (ongoing care) | ☐ **Retrospective:** Request for services already rendered without prior authorization |

**Standard**
- Preauthorization = 3 business days
- Concurrent = 1 business day
- Retrospective = 30 calendar days

**Expedited:** The expedited review request is subject to denial if there is no documented life-threatening condition or imminent danger to the member's health. If a request to expedite a review is denied, a determination will be made within the standard timeframe. Retrospective reviews are not eligible for expedited review.

## MEMBER INFORMATION

| | | |
|---|---|---|
| Name: | ID#: | Date of Birth: |
| Street Address: | | |
| ICD-10 Diagnosis Codes(s): | | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Name: | ID#/TIN/NPI: | |
| Street Address: | | |
| Phone Number: | Fax Number: | Contact Name: |

## REQUESTED SERVICE INFORMATION

| Dates of Service | From: | To: | # of visits (if applicable): |
|---|---|---|---|

| CODE | QUANTITY/UNITS | CODE | QUANTITY/UNITS | CODE | QUANTITY/UNITS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## PLACE OF SERVICE

**INPATIENT**
- ☐ 13 Assisted Living Facility
- ☐ 21 Inpatient Hospital
- ☐ 31 Skilled Nursing Facility
- ☐ 32 Nursing Facility
- ☐ 33 Custodial Care Facility
- ☐ 34 Hospice Revenue Code _____

**ADMISSION TYPE**
- ☐ Elective Admission
- ☐ Emergent Admission
- ☐ Custodial Care
- ☐ Long-Term Placement

**OUTPATIENT**
- ☐ 02 Telehealth- Not in the home
- ☐ 03 School
- ☐ 04 Homeless Shelter
- ☐ 10 Telehealth- In the Home
- ☐ 11 Office
- ☐ 12 Home
- ☐ 13 Assisted Living Facility
- ☐ 14 Group Home
- ☐ 15 Mobile Unit
- ☐ 19 Off-Campus Outpatient Hospital
- ☐ 20 Urgent Care Facility
- ☐ 22 On Campus- Outpatient Hospital
- ☐ 23 Emergency Room- Hospital
- ☐ 24 Ambulatory Surgical Center
- ☐ 25 Birthing Center
- ☐ 34 Hospice Revenue Code _____
- ☐ 41 Ambulance- Land
- ☐ 42 Ambulance Air or Water
- ☐ 49 Independent Clinic
- ☐ 50 Federally Qualified Health Ctr
- ☐ 65 ESRD Treatment Facility
- ☐ 81 Independent Laboratory
- ☐ 99 Other