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PRIOR APPROVAL REQUEST

MEMBER INFORMATION	REQUESTING PHYSICIAN (Must be in plan)
Today's Date: _____ / _____ / _____ Name: _____ Date of Birth: _____ / _____ / _____ ID#: _____	DIAGNOSIS(ES) _____ Name: _____ Provider #: _____ Address: _____ _____ Name of Contact: _____ Telephone Number of Contact: _____

CHOOSE YOUR REQUEST TYPE:

<input type="checkbox"/> HOSPITALIZATIONS ___ Inpatient Admission ___ Surgical Day ___ Observation Admit Date: _____ / _____ / _____ Procedure/CPT Code(s): _____ _____ Admitting Physician: _____ Address: _____ _____ Phone: _____ Fax: _____ Facility: _____ Address: _____ _____ Phone: _____ Fax: _____ ___ In-plan ___ Out-of-Plan _____ # of Pre-Op _____ # of Post-Op	<input type="checkbox"/> DURABLE MEDICAL EQUIPMENT Provider: _____ Provider # _____ Address: _____ _____ Phone: _____ Fax: _____ HCPC _____ # of Units _____ HCPC _____ # of Units _____ HCPC _____ # of Units _____ HCPC _____ # of Units _____ Prescribing Physician: _____ Phone: _____ Orders: _____ ___ Out-of-Plan Rationale for utilizing an out-of-plan provider: _____
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OUT-OF-PLAN OUTPATIENT SERVICES – Please note: HNE does not verify the credentials of Non-Plan Providers. Any Imaging services (MRI, CT, PET) must be performed in-plan.

___ Second Opinion Only: Submit office notes from the in-plan treating specialist related to request

___ Evaluation: Submit office notes from the in-plan treating specialist related to request

___ Follow-Up: Submit office note from the last visit.

___ Student/Travel: Submit any pertinent documentation.

Rationale: _____

Member's in-plan treating specialist: _____
 Physician Requested: _____
 Specialty: _____
 Address: _____

 Phone: _____ Fax: _____

Procedure Name: _____
 CPT Codes: _____

Date of Visit: _____ / _____ / _____ # of Visits _____

Comments: _____

<input type="checkbox"/> IN-PLAN OUTPATIENT SERVICES Provider: _____ Provider #: _____ Specialty: _____ Address: _____ _____ Phone: _____ Fax: _____	Service/CPTCode(s): _____ <input type="checkbox"/> In office <input type="checkbox"/> Other: _____ Number of Visits: _____ Frequency: _____ * Note: Submit office notes from inplan Doctor related to request PLASTIC SURGEONS ONLY: Will this be the only surgery being performed? <input type="checkbox"/> YES or <input type="checkbox"/> NO
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Prior approval is not a guarantee of payment. All payment of claims is contingent upon verification of: (1) The member's eligibility on the date of service, (2) The medical necessity of the care, and (3) Coordination of Benefits/Subrogation status. For information regarding timeframes please contact the Health Services Department at 413-787-4000 or 800-842-4464, extension 5027.

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