Keystone First
Community HealthChoices

Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
All fields must be completed for the request to be processed.
Please make a selection where applicable throughout the document.

DATE			
TYPE OF REQUEST	_____ URGENT	_____ STANDARD	_____ RETROSPECTIVE
TREATMENT SETTING	_____ INPATIENT	_____ OUTPATIENT	
REQUEST TYPE	_____ EXTENSION	_____ INITIAL	_____ CANCEL _____ CHANGES DOS/SETTING
_____ ADDITIONAL CLINICAL	_____ DISCHARGE PLANNING	_____ OTHER	
PREVIOUS AUTHORIZATION NUMBER			
CONTACT NAME			
CONTACT PHONE	CONTACT FAX		

PARTICIPANT INFORMATION

LAST NAME		
FIRST NAME		
PARTICIPANT ID (MEDICAID ID OR HEALTH PLAN ID)		
PARTICIPANT PHONE NUMBER	DATE OF BIRTH	
PARTICIPANT STREET ADDRESS		
CITY	STATE	ZIP

PROVIDER INFORMATION

PROVIDER NAME			
PROVIDER TIN	PROVIDER NPI		
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER		
PROVIDER STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			
FACILITY NAME			
FACILITY TIN	FACILITY NPI		
FACILITY PHONE NUMBER	FACILITY FAX NUMBER		
FACILITY STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)			
REFERRING PHYSICIAN TIN			
REFERRING PHYSICIAN NPI			
REFERRING PHYSICIAN PHONE NUMBER			
REFERRING PHYSICIAN FAX NUMBER			
REFERRING PHYSICIAN STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

MEDICAL SECTION

DIAGNOSIS CODE		

PROCEDURE CODE	START DATE	END DATE	NUMBER OF UNITS	CODE DESCRIPTION

MEDICAL SECTION

NOTES

PLEASE FAX TO
PRIOR AUTHORIZATION, RETRO PRIOR AUTHORIZATION, AND OB: **1-855-540-7066**
DME: **1-855-540-7067**

WHEELCHAIR/POWERED VEHICLE PLEASE NOTE: HOME ASSESSMENT IS NECESSARY FOR ALL MANUAL WHEELCHAIRS, POWER WHEELCHAIRS, AND SCOOTERS. DHS PRESCRIPTION FORM FOR MOTORIZED WHEELCHAIRS IS NECESSARY FOR ALL POWER WHEELCHAIR AND SCOOTER REQUESTS.

URGENT MEDICAL CONDITION: ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.

IMPORTANT PAYMENT NOTICE: PLEASE NOTE THAT REIMBURSEMENT FOR ALL RENDERING NETWORK PROVIDERS SUBJECT TO THE ORDERING/REFERRING/PRESCRIBING (ORP) REQUIREMENT FOR AN APPROVED AUTHORIZATION IS DETERMINED BY SATISFYING THE MANDATORY REQUIREMENT TO HAVE A VALID PENNSYLVANIA MEDICAL ASSISTANCE (MA) PROVIDER ID. CLAIMS SUBMITTED BY RENDERING NETWORK PROVIDERS THAT ARE SUBJECT TO THE ORP REQUIREMENT WILL BE DENIED WHEN BILLED WITH THE NPI OF AN ORP PROVIDER THAT IS NOT ENROLLED IN MA.

TO CHECK THE MA ENROLLMENT STATUS OF THE PRACTITIONER ORDERING, REFERRING, OR PRESCRIBING THE SERVICE YOU ARE PROVIDING, VISIT THE DHS PROVIDER LOOK-UP PORTAL. **HTTPS://PROMISE.DPW.STATE.PA.US/PORTAL/DEFAULT.ASPX?ALIAS=PROMISE.DPW.STATE.PA.US/PORTAL/PROVIDER**

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