Sentara Health Plans

PO Box 66189
Virginia Beach, VA 23466

Authorization Request Form for Commercial Behavioral Health Outpatient Services

Authorization requirements can be found at pal.sentarahealthplans.com.

Priority	Fax Number
Nonurgent	757-431-7763 / 1-844-723-2096

Note: Both local and toll-free fax numbers have been listed. Please do not fax to both fax numbers as this may delay processing your request.

Check here if urgent ☐

The National Committee for Quality Assurance (NCQA) defines an urgent request as a request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:

- **Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgement, *or***
- **Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, *or***
- **In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.**

Please submit clinical documentation to support medical necessity to the appropriate fax number.

Member Information		
Name:	**DOB:**	**ID#:**
Diagnosis Code(s):		

Type of Service			
	Partial Hospitalization Program (PHP)		Intensive Outpatient Program (IOP)
	Applied Behavioral Analysis (ABA)		Electroconvulsive Therapy (ECT)
	Repetitive Transcranial Magnetic Stimulation (rTMS)		Psych Testing
	Office Visit(s)		Other - Please specify:

Outpatient Procedure Codes / Diagnostic Services			
CPT/HCPC Code(s)	**Units or Days**	**Description**	**Date of Service**

Completed By					
Name:					
Phone:		**Ext:**		**Fax:**	

Requesting Provider Provider requesting the procedure or service to be performed			
Name:		**Group Name:**	
NPI:		**Tax ID:**	
Phone:		**Fax:**	

Treating Provider/Facility Facility or location where the procedure or service is being completed			
Name:			
NPI:		**Tax ID:**	
Phone:		**Fax:**	
Place of Service:			

Important: Please submit all supportive clinical documentation to substantiate the need for service to include office notes with treatment plans and medications. For IOP/PHP requests, include treatment days per week. For TMS requests, include number of treatment days per week and Hertz (Hz). For ABA, include autism diagnosis date and diagnosing provider along with treatment plan. For ECT, include medical clearance and pharmacotherapy.