Sentara Health Plans

PO Box 66189
Virginia Beach, VA 23466

Authorization Request Form for Commercial Outpatient Services

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

Priority	Fax Number
Nonurgent	757-431-7761 1-844-723-2094
Urgent	757-822-6205 1-844-715-6322
Medications *Complete specialty medication request form if applicable	757-431-7757 1-844-668-1550

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. For required photos, submit them to SHP_COMM_Photos@sentara.com.

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

Outpatient Procedure Codes / Diagnostic Services / Drug Name			
CPT/HCPC/ J Code(s)	**Units or Dose**	**Description (Frequency if medication)**	**Date of Service**

Outpatient Therapy

Authorization for the codes below will authorize all allowed treatment codes

Select	Type	# of Visits	Start Date	End Date
☐	Physical Therapy 97110			
☐	Occupational therapy 97530			
☐	Speech Therapy 92507			

Home Health Therapy

Type	HCPC code(s)	# of Visits	Start Date	End Date
Skilled Nursing				
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Medical Social Worker				
Home Health Aide				

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 procedure or service is being completed

Name:			
NPI:		Tax ID:	
Phone:		Fax:	
Place of Service:	☐ OP Hospital ☐ ASC ☐ Office ☐ Home Health ☐ Infusion Center ☐ Other		