

## Authorization Request Form for Commercial Outpatient Services

Authorization requirements can be found at [pal.sentarahealthplans.com](http://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](mailto: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

<b>Outpatient Therapy</b> Authorization for the codes below will authorize all allowed treatment codes			
<b>Select</b>	<b>Type</b>	<b># of Visits</b>	<b>Start Date</b>
<input type="checkbox"/>	Physical Therapy 97110		
<input type="checkbox"/>	Occupational therapy 97530		
<input type="checkbox"/>	Speech Therapy 92507		
<b>Home Health Therapy</b>			
<b>Type</b>		<b>HCPC code(s)</b>	<b># of Visits</b>
Skilled Nursing			
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Medical Social Worker			
Home Health Aide			
<b>Completed By</b>			
<b>Name:</b>			
<b>Phone:</b>		<b>Ext:</b>	<b>Fax:</b>
<b>Requesting Provider</b> Provider requesting the procedure or service to be performed			
<b>Name:</b>		<b>Group Name:</b>	
<b>NPI:</b>		<b>Tax ID:</b>	
<b>Phone:</b>		<b>Fax:</b>	
<b>Treating Provider/Facility</b> Facility or location where procedure or service is being completed			
<b>Name:</b>			
<b>NPI:</b>		<b>Tax ID:</b>	
<b>Phone:</b>		<b>Fax:</b>	
<b>Place of Service:</b>	<input type="checkbox"/> OP Hospital <input type="checkbox"/> ASC <input type="checkbox"/> Office <input type="checkbox"/> Home Health <input type="checkbox"/> Infusion Center		