



REQUEST FOR AUTHORIZATION OF SERVICES

EMAIL or FAX THIS FORM

Email: UM@LibertyMedicareAdvantage.com

Fax: 1-877-760-3820 For questions: 1-844-854-6884

Standard Expedited/Medically Urgent* Retro

Provider/Facility

Prescribing Provider Name: _____ NPI: _____
 Name and Credentials of person making request: _____
 Phone: _____ Fax: _____ Email: _____
 Servicing Provider/Facility : _____ NPI: _____
 Inpatient Admission Date: ____/____/____ Estimated Length of Stay: _____ days
 Part A SNF (post hospitalization) ____/____/____ Estimated Length of Stay: _____ days
 Part A Skill-in-Place ____/____/____ Estimated Length of Stay: _____ days
 Additional Part A Days: _____ Reason: _____
 Outpatient Diagnostic/Service: ____/____/____ CPT: _____
 Part B Drug: _____
 DME: _____

Member Data

Name: _____ Date of Birth: _____
 Plan ID/MBI: _____
 Nursing Facility: _____
 Is Requesting Provider : Plan NP PCP Plan PA Other _____
 Diagnosis (ICD10) Related to Request: _____

Part B/Therapy

REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

PT Initial Visits Date of Eval ____/____/____ Plan: _____ days per week for _____ weeks
 Goals in Place ___Yes ___ No

Additional PT Visits # requested _____ Plan: _____ days per week for _____ weeks
 Goals Updated ___Yes ___ No

Member Actively Participating? ___Yes ___ No Functional Progress Made? ___Yes ___ No Demonstrates Potential to Improve? ___Yes ___ No

OT Initial Visits Date of Eval ____/____/____ Plan: _____ days per week for _____ weeks
 Goals in Place ___Yes ___ No

Additional OT Visits # requested _____ Plan: _____ days per week for _____ weeks
 Goals Updated ___Yes ___ No

Member Actively Participating? ___Yes ___ No Functional Progress Made? ___Yes ___ No Demonstrates Potential to Improve? ___Yes ___ No

ST Initial Visits Date of Eval ____/____/____ Plan: _____ days per week for _____ weeks
 Goals in Place ___Yes ___ No

Additional ST Visits # requested _____ Plan: _____ days per week for _____ weeks
 Goals Updated ___Yes ___ No

Member Actively Participating? ___Yes ___ No Functional Progress Made? ___Yes ___ No Demonstrates Potential to Improve? ___Yes ___ No

* I CERTIFY BY SIGNING BELOW THAT WAITING FOR A DECISION LONGER THAN 72 HOURS COULD PLACE THE MEMBER'S LIFE, HEALTH, OR ABILITY TO GAIN MAXIMUM FUCTION IN SERIOUS JEOPARDY.

NAME: (print) _____ SIGNATURE: _____

PLEASE DO NOT SEND REQUEST FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX--MUST SEND SEPARATELY