LIBERTY MEDICARE ADVANTAGE
Planning your advantage

REQUEST FOR AUTHORIZATION OF SERVICES

EMAIL or FAX THIS FORM
UM@LibertyMedicareAdvantage.com
Fax: 1-877-760-3820 For questions: 1-844-854-6884

☐ Standard ☐ Expedited/Medically Urgent*

Provider/Facility

Requesting Provider Name _____
NPI_____ Tax ID _____
Phone _____Fax_____Email_____
Servicing Provider/Facility_____NPI_____TAX ID_____
Inpatient Admission Stay _____/_____/_____Estimated Length of Stay _____days
Observation Stay _____/_____/_____Estimated Length of Stay _____days
Is this Level of Care Change – Observation to Inpatient _____Yes _____No
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: _____ Procedures: _____
Part B Drug: _____
DME: _____
Clinicals Required with Form Submission

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

TYPE ☐ PT ☐ OT ☐ ST

Initial Visits: Date of Evaluation_____ Plan _____days per week for _____ weeks

Additional Visits # Requested_____ Plan _____days per week for _____weeks

Goals Updated ☐ Yes ☐ No

Member Actively Participating: _____ Functional Progress Made _____

Demonstrates Potential to Improve _____

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 function in serious jeopardy.
Name (print)_____ Signature _____
Submission of this form does not guarantee payment.