



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

Provider Name, NPI, Tax ID, Phone, Fax, Email, Servicing Provider/Facility, NPI, TAX ID, Inpatient Admission Stay, Observation Stay, Part A SNF, Part A Skill In Place, 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, weeks, Additional Visits, # Requested, Plan, days per week, 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.