



FAX 1-888-291-4542

**Health Choice Generations Medicare Advantage
Special Needs Plan PRIOR AUTHORIZATION FORM**

**ALL SECTIONS MUST BE COMPLETED & MEDICAL
DOCUMENTATION MUST BE PROVIDED**

Member Name _____

Date of birth _____

HC Generations ID# _____

Specialist Consult To: _____

Name of Procedure(s): _____

Contracted facility to be used: _____

Date Scheduled (if known): _____

Ancillary Service Request: _____, OR

Physical Therapy Occupational Therapy Speech Therapy
Number visits / Time Span requested:

_____ / _____

Diagnosis/ICD-9code _____ / _____

Diagnosis/ICD-9code _____ / _____

Procedure/CPTcode _____ / _____

Procedure/CPTcode _____ / _____

Date: _____

Requesting Provider: _____

PCP (If different) _____

Office Contact:
Phone #: _____
Fax #: _____

**To request PA, Non-Formulary Med, or to
exceed maximum dose/quant. limitations**
Name of Med: _____
Dosage/Sig: _____
Quantity: _____ Refills _____

Part D Medication Request Determination ALL OTHER Medical Service Requests

Mark One: Standard (< 72 hrs) Expedited (< 24 hrs) **///** Standard (<14 days) Expedited (<72 hrs)

Providers must use Expedited only when medically necessary! Inappropriate use of
An Expedited request is not acceptable and can delay timely attention to true Expedited requests.
Inappropriate Expedited requests may be down graded to Standard by HCG.

Response to Provider: Health Choice has considered the above request and has made the following determination:

Approved

Denied For the Following Reason(s):

- No notes were received with the request by HCG in order to evaluate for medical necessity.
- No documentation of medical necessity based on the information received for review by HCG.
- No documentation of trial/failure of conservative medical treatment(s) by the referring provider.
- No documentation of trial and/or failure of formulary medications OR a need to exceed plan limits.
- Formulary choices/other choices in this class/for this diagnosis are available without prior authorization.
- The preferred prior authorization formulary medication choice was not requested.

Denial letter type: _____

Medical Director Sig: _____ Date of Decision: _____

*****PROVIDERS MUST FILL OUT FORM COMPLETELY AND SEND MEDICAL
DOCUMENTATION WHICH SUPPORT THE REQUESTED SERVICE.
FAILURE TO DO SO MAY RESULT IN A DENIAL OF SERVICE*****