VILLAGECAREMAX

Fax this form to 718-517-2709

REQUEST FOR PRIOR AUTHORIZATION

This form should be completed and faxed to VILLAGECAREMAX PLAN within 24 hours of an urgent/emergent admission, and no less than 2 weeks prior to a request for an elective service. This form must be accompanied by all clinical information which includes medical history, results of physical exam, diagnostic tests, lab test results, functional problems, presenting symptoms and treatment plan. Incomplete requests will delay the authorization process and/or result in an adverse determination. Authorization is pending confirmation of member eligibility at time of service. If approved, authorization for service does not constitute a guarantee of payment by VillageCareMAX. If you have any question, please call us at (800)469-6292

If this is an expedited request, as the provider, do you believe that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy? Yes/No. If you answered No, this authorization request will be reviewed under the standard timeframe.

Member Name: _________________ D.O.B__/__/____ Member ID #:___________ Medical Record# (MRN):________________

Request Date __/__/____ L.O.B. _______________

Contact Person: _______________________________ Contact Phone: ____________________ Contact Fax:________________

If non-participating provider, please check here Please state reason for out-of-network service:

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Tax ID and NPI must be submitted at time of request.

Name of Service Facility: ____________________________ Servicing Facility NPI #:____________________________________

Servicing Provider Name ____________________________ **Referring Provider Name**: __________________________________

Servicing Provider TIN #: _____________________________ Referring Provider TIN #: ___________________________________

Servicing Provider NPI #: _____________________________ Referring Provider NPI #: ___________________________________

If this is an expedited request, as the provider, do you believe that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy? **Yes / No** If you answered **No**, this authorization request will be reviewed under the standard timeframe.

Physician Signature: ____ Date:____/_____/_________

Please select appropriate service and summit appropriate codes.

Place of Service: ____

Elective Inpatient Admission	Home Care/CHHA	Physical/Occupational/Speech Therapy
Acute Inpatient Admission	Durable Medical Equipment (DME) Rental / Purchase	Other (Please specify
Short Term/Acute Rehab	Skilled Nursing Facility	
Elective Outpatient/Ambulatory Procedure	Diagnostic Services	

Service Start Date: _________________________________Service End Date: ____

Primary Diagnosis Code(s):____

Procedure/HCPCS Code:____

Documentation Attached to Support Request Includes:

Clinical Notes Lab Results X-Ray Reports Other

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