KeyCare ADVANTAGE

REQUEST FOR AUTHORIZATION OF SERVICES FORM

Call UM at: 844-206-1205 (Call Center Hours M-F 8a– 8p) ***FAX Form and Clinical to 833-610-2399***

****** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY***

***PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage.

MEMBER DATA

_______________ **Member Name** _______________ **Date of Birth** _______________ **Member's Plan ID**

_______________ **Name of Nursing Facility** _______________ **Referring Provider**

Is Referring Provider: ☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other

Diagnoses (ICD-10 Codes) Related to Auth Request _______________

PART A and OUTPATIENT SERVICE

SERVICES REQUESTED (include copy of order or clinical note for out-of-network requests)

☐ **Part A SNF (post hospitalization)** **Start Date**_______________ **# of Days Requested** _______________

☐ **Part A Skill-in-Place** **Start Date**_______________ **# of Days Requested** _______________

☐ **Additional Part A Days** **Reason:** _______________ **# of Days Requested**_____

☐ **Outpatient Diagnostic or Service** **Date of Procedure/Service**_______________

CPT Code or Name of Procedure/Service: _______________

Provider or Facility Name (REQUIRED): _______________

Provider or Facility Contact Number (REQUIRED): _______________

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization Request**

☐ **Expedited Authorization (Must Read and SIGN)**: By signing below I certify 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**.

Signature for Expedited Review Only: _______________

Name of Person Completing this Form:_______________ **Date Completed:** _______________

Contact #: _______________ **Contact FAX:** _______________