HealthCare Partners, MSO

501 Franklin Avenue, Suite 300
Garden City, New York 11530
Phone: (516) 746-2200 (888) 746-2200

AUTHORIZATION REQUEST

Date: _____

FAX TO
(516) 394-5684 for Specialty Drugs
or
(516) 515-8806 for Oncology

☐ **STANDARD** (Routine) **Request** - PLEASE DO NOT USE ASAP, URGENT, or STAT; these are not recognized by CMS.

☐ **EXPEDITED Request** - **ALL EXPEDITED Requests MUST meet the CMS definition and be Attested to:**

Provider Attestation Required ***(Expedited Requests Only)***

Clinical justification for expedited review: _____

_____

By signing below, I certify that applying the standard review timeframe for this service request may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Physician/clinician name: _____ **Signature:** _____

Member Information

Name (Last, First MI)		*DOB*
Address (Street)	*City, State ZIP Code*	
Health Plan	**Member ID#**	**Area Code & Telephone No.**

Referring Physician (PCP or Specialist)		**Referred to (HCP or Health Plan Par-Provider)**	
Name (Last, First MI)		*Name (Last, First MI)*	
Address (Street, City, State ZIP Code)		*Address (Street, City, State ZIP Code)*	
Area Code & Telephone No.	*Area Code & Fax No.*	*Area Code & Telephone No.*	*Area Code & Fax No.*
Specialty	*Are you referring to yourself?*	*Specialty*	if PSN Provider ☐

Requested Service(s) – ALL FIELDS MUST BE COMPLETED

Diagnosis(es):	**ICD-10 Code(s):**
Indicate Medical Necessity:	
	Clinical Notes/Reports Attached: ☐ Yes ☐ No
Service(s) Requested:	***CPT Code(s):***

Place of Service: ☐ **Office (POS11)** ☐ **Home(POS 12DME/Homecare)** ☐ **Outpatient Hospital ON campus (POS 22)**
☐ **Outpatient Hospital OFF campus(POS 19)** ☐ **Ambulatory Surgery Center (POS 24)** ☐ **Inpatient Hospital (POS 21)**

FACILITY NAME:_____

HealthCare Partners will notify you of the determination made on your request for service(s)
Services Not Prior Approved By HCP, MSO Are Not Payable*

IMPORTANT NOTE TO HCP CONTRACTED AND NON-CONTRACTED PROVIDERS

The approval of the services indicated above refers only to the medical appropriateness of the requested service(s) and does not represent guarantee of payment. Your acceptance of this referral to provide services to the above-referenced member/patient constitutes your agreement to accept payment in accordance with HealthCare Partners, IPA reimbursement fee schedule (which may change from time to time without notice) as payment in full, and look to the member/patient only for payment of applicable co-payment and/or deductibles. *Payment is limited to those service(s) specifically authorized; any additional services require further authorization from HealthCare Partners, MSO subject to modifications as may be posted on the HCP, IPA Website from time to time.You further agree to abide by HealthCare Partners' Claims, Quality and Utilization Management policies currently in effect. **REIMBURSEMENT IS SUBJECT TO MEMBER'S ELIGIBILITY TO RECEIVE BENEFITS ON THE DATE OF SERVICE**. **Claims for authorized services must be received within 90 days of the date of service to be considered for payment.**

CHEMOTHERAPY/MEDICATION REQUEST

Date: _____

NOTE: IF THIS IS THE FIRST REQUEST FOR THESE MEDICATIONS, ADDITIONAL CLINICAL INFORMATION INCLUDING: CONSULTATION, PATHOLOGY, RADIOLOGY AND APPROPRIATE LABORATORY TESTS ARE NECESSARY TO SUPPORT THIS REQUEST.

NAME: _____
ID #: _____
SEX: MALE ☐ FEMALE ☐
HEIGHT: _____ WEIGHT: _____ BSA: _____
STAGE: _____

PLEASE NOTE: HCP AUTHORIZES FOR 60-DAY INTERVALS

J-CODE	BRAND NAME	GENERIC NAME OF DRUG	DOSE/M^2	ACTUAL CALCULATED DOSE	CYCLE LENGTH*	FREQUENCY OF ADMIN W/IN CYCLE

***CYCLE LENGTH EXAMPLE: WEEKLY, MONTHLY, ETC.**
NUMBER OF CYCLES: _____

IS THE PHYSICIAN PROVIDING THE MEDICATION? YES ☐ NO ☐

MEDICATION INFUSION/INJECTION CODES:
96365 ☐ 96368 ☐ 96376 ☐ 96411 ☐ 96416 ☐ 96366 ☐ 96372 ☐ 96401 ☐
96413 ☐ 96450 ☐ 96367 ☐ 96374 ☐ 96402 ☐ 96415 ☐
Other: _____

HYDRATION CODES:
96360 - _____ 96361 - _____ 96572 - _____

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