AmeriHealth Caritas Delaware

Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
All fields must be completed for the request to be processed.
Please make a selection where applicable throughout the document.

DATE	
TYPE OF REQUEST	_____ URGENT _____ STANDARD _____ RETROSPECTIVE
TREATMENT SETTING	_____ INPATIENT _____ OUTPATIENT
REQUEST TYPE	_____ EXTENSION _____ INITIAL _____ CANCEL _____ CHANGES DOS/SETTING
	_____ ADDITIONAL CLINICAL _____ DISCHARGE PLANNING _____ OTHER
PREVIOUS AUTHORIZATION NUMBER	
CONTACT NAME	
CONTACT PHONE	CONTACT FAX

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID (MEDICAID ID OR HEALTH PLAN ID)		
MEMBER PHONE NUMBER	DATE OF BIRTH	
MEMBER STREET ADDRESS		
CITY	STATE	ZIP

PROVIDER INFORMATION

PROVIDER NAME			
PROVIDER TIN	PROVIDER NPI		
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER		
PROVIDER STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			
FACILITY NAME			
FACILITY TIN	FACILITY NPI		
FACILITY PHONE NUMBER	FACILITY FAX NUMBER		
FACILITY STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)			
REFERRING PHYSICIAN TIN			
REFERRING PHYSICIAN NPI			
REFERRING PHYSICIAN PHONE NUMBER			
REFERRING PHYSICIAN FAX NUMBER			
REFERRING PHYSICIAN STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

MEDICAL SECTION

DIAGNOSIS CODE		

PROCEDURE CODE	START DATE	END DATE	NUMBER OF UNITS	CODE DESCRIPTION

MEDICAL SECTION

NOTES

PLEASE FAX TO:

- PRIOR AUTHORIZATION FAX: **1-866-497-1384**
- PRIOR AUTHORIZATION RETRO FAX: **1-866-423-1081**
- DME FAX: **1-844-688-2983**
- OB REQUEST FAX: **1-866-497-1384**

Providers are responsible for obtaining prior authorization before services are rendered. Service rendered without prior authorization may result in a denial. Please submit clinical information to support medical necessity of the request. Request will not be processed if clinical information or CPT and ICD-10 codes are missing. Authorization is not a guarantee of payment. If you have an urgent request, please call **1-855-396-5770** to initiate the review process.

Other Clinical Information
Include or attach any clinical and office notes, doctor's orders, labs, and imaging reports to support medical necessity.
If this is an out-of-network request, please provide an explanation and complete the nonparticipating provider form.

Important payment notice
Please note that reimbursement to any rendering provider for an approved authorization is determined by satisfying the mandatory requirement to have a valid Delaware Medical Assistance (MA) provider ID. However, effective January 1, 2018, any claim submitted by a rendering provider will be denied if it is submitted without the ordering/prescribing/referring provider's Delaware MA enrolled NPI, or if the NPI does not match that of a Delaware MA enrolled provider.

To check the Delaware MA enrollment status of the practitioner that is ordering, referring, or prescribing the service you are providing, visit the Delaware Department of Health and Social Services (DHS) provider look-up portal at: **https://medicaid.dhss.delaware.gov/provider**.

AmeriHealth Caritas™
Delaware