REQUEST FOR PRIOR AUTHORIZATION

Date of Request* __ / __ / ____

*Required items. Please write only in designated areas.

superior healthplan™

Member Information

Member ID*

Date of Birth* __ / __ / ____

Last Name

First Name

Provider to Perform the Service

1740681683 NPI*

343894701 TPI*

471708839 Tax ID*

OHANA PEDIATRIC HH

Last Name, First Initial or Facility Name

210 451 8554 Fax Number*

210 451 8555 Contact Number*

INTAKE

Contact Name / Requestor

Submitting / Referring / Performing Provider

☐ 'X' in box if same as above.

NPI*

Tax ID*

Last Name, First Initial or Facility Name

Fax Number*

Contact Number*

Contact Name / Requestor

Requested Service

Type of Service

☐ DME Rental* ☐ DME Purchase* ☐ DME Incontinence Supply*

☒ Home Health ☐ SNV ☐ PDN ☒ Therapy

☐ Genetic Testing Type:_____ Pregnant ☐ Yes ☐ No

☐ Outpatient Services ☐ Office Visit

☐ Rehab ☐ Evaluations ☐ Re-Evaluations

☐ Non-Emergent Transportation

☐ Inpatient

☐ Other _____

LTSS Services

☐ PAS

☐ DAHS

☐ ERS

☐ Home Delivered Meals

☐ Med Box Refills

☐ Other _____

Place of Service*

☐ Office

☐ Outpatient Hospital / ASC Gen

☒ Home

☐ Outpatient Clinic

☐ Outpatient Rehab

☐ Inpatient

☐ Other_____

*All DME require signed physician orders. All HH and Rehab requests require signed physician's order and plan of care/treatment plan.

Clinical Review

Procedure Codes

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Procedure code / CPT, HCPCS* modifier

Diagnosis

Referring Diagnosis Code*

Referring Diagnosis Code

☐ 'X' indicates clinicals or plan of care

Service Description

__ / __ / ____ Start date*

__ / __ / ____ End date*

Units / Visits* X ☐ Day ☐ Week ☐ Month

Contact Information

Fax Numbers:

LTSS Bexar:	866-224-8254
LTSS Nueces:	866-703-0903
Admissions:	888-886-0170
Referrals:	800-690-7030
Hotline:	800-218-7508

☐ Urgent Request - By checking this box, I certify that this is an urgent request medically necessary treatment, which must be treated within 24 hours.

_____

Signature of Requesting Physician *(required)*

Superior requires services be approved before the service is rendered. Please refer to the SHP website, www.SuperiorHealthPlan.com for the most current full listing of authorized procedures and services. Note that an authorization is not a guarantee of payment and is subject to utilization management review, benefits and eligibility.

For Office Use Only

Authorization Number: _____

Units: _____

Dates Authorized: _____