AmeriHealth Caritas
New Hampshire

Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THE "STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM". A COPY OF ALL SUPPORTING INFORMATION IS REQUIRED. LACK OF INFORMATION MAY RESULT IN DELAY OR DISMISSAL OF REQUEST.

Prior Authorization request form and required clinical information should be sent to:
Utilization Management
Fax: 1-833-469-2264
For assistance, please call: 1-833-472-2264

☐ Urgent ☐ Standard

Service Type Requiring Authorization (Check all that apply)		
Ambulatory/Outpatient Services ☐ Surgery/Procedure ☐ Chiropractic **Pharmacy** ☐ Systemic Immunomodulators ☐ Hyaluronic Acid Derivative Injections	**Home Health/Hospice** ☐ Home Health (Please check: ☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ MSW) ☐ Personal Care Attendant (Please include SCFE form) ☐ Hospice ☐ Infusion Therapy	**Outpatient Therapy** (Out of Home Only) ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Pulmonary/Cardiac Rehab ☐ ABA Therapy
Inpatient Care/Observation ☐ Acute Medical/Surgical ☐ Long Term Acute Care ☐ Acute Rehab ☐ Skilled Nursing Facility ☐ Observation	**Nutrition** ☐ Nutritional Counseling ☐ Enteral Nutrition ☐ Infant Formula ☐ Total Parental Nutrition	**Dental** ☐ Anesthesia ☐ Misc (specify in other below) ☐ **Out of Network Request—please specify service:**
☐ **Other — please specify service:**		

Member Information (*Denotes required field)	
*Member ID:	*Date of Birth:
*Last Name, First Name:	

Requesting Provider Information (*Denotes required field)			
*Requesting NPI:	*Requesting TIN:	*Requesting Provider:	
Contact at Requesting Provider's Office:	*Phone:	*Fax:	

Servicing Provider/Facility Information (*Denotes required field)		
*Please choose one: ☐ Participating ☐ Non-participating	*Servicing NPI:	*Servicing TIN:
*Servicing Provider:	*Servicing Facility Name:	
*Contact at Servicing Provider's Office:	*Phone:	*Fax:

Authorization Request (* (*Denotes required field)	
*Primary Procedure Code(s):	*Start Date OR Admission Date:
	*Diagnosis Code:
	*End Date OR Discharge Date:
	Total Units/Visits/Days:
*Additional Procedure Code(s):	Additional Comments:

Please refer to the following payer web site for additional information regarding plan specific requirements for services that require prior authorization.
AmeriHealth Caritas New Hampshire: www.amerihealthcaritasnh.com

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

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