Outpatient Preauthorization Request Form

Please complete each section of this form. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained. Decisions are based on eligibility, benefit determination and medical necessity.

****Incomplete forms will not be processed; this form must be filled out completely.**

Member's Name: _____ Member's DOB: _____

Member's ID Number: _____ Group Number: _____

ICD code(s), please list all that apply: _____

CPT & HCPCS code(s), please list all that apply: _____

Place of Service: _____

NPI/Tax ID Number: _____

Admission/Procedure/Service Date: _____ Days/Units Requested: _____

Outpatient Services

- ☐ Ambulance/Transportation
- ☐ Anesthesia
- ☐ Applied Behavioral Analysis Therapy
- ☐ Breast Reconstruction/Reduction
- ☐ Chiropractic Services
- ☐ Clinical Trial
- ☐ Dental
- ☐ Diagnostic Services
- ☐ Endovenous Ablation Therapy
- ☐ Gastric/Weight Loss Surgery
- ☐ Genetic/Pharmacogenetic Testing
- ☐ Hernia Repair
- ☐ Home Health Care Services
- ☐ Hospice
- ☐ Hysterectomy
- ☐ Infertility Diagnostic Services
- ☐ Mastectomy
- ☐ Pain Management Services
- ☐ Occupational Therapy*
- ☐ Orthotics & Prosthetics
- ☐ Radiation Oncology
- ☐ Physical Therapy*
- ☐ Plastic/Reconstructive Surgery
- ☐ Speech Therapy*
- ☐ Referral
- ☐ Residential Treatment
- ☐ Substance Abuse Treatment
- ☐ Spinal Disc Replacement
- ☐ Spine Fusion
- ☐ Other: _____
- ☐ TMS Therapy
- ☐ Transplant Services, type: _____

* Only required if over their limited number of visits. Please specify the number of additional visits being requested: _____

In-Network Benefits for an Out-of-Network Provider

Second opinion: _____

Higher level of care/expertise. Explain: _____

Clinical urgency/severity of condition. Explain: _____

Unreasonable appointment wait time with in-network provider. Explain: _____

Other. Explain: _____

Continuity of Care Request

Member has an acute medical condition and is receiving active care. Condition: _____

Member is receiving mental health/substance abuse treatment. Type of Treatment: _____

Member has a terminal illness. Condition: _____

Member is pregnant. Due date: _____

Member is receiving care for active cancer including chemotherapy or radiation: _____

Member is receiving care for a recent major surgery or trauma. List surgery/trauma: _____ Date of occurrence: _____

Member is scheduled for a surgery or hospitalization. Type of surgery or hospitalization: _____ Scheduled date: _____

Member received a transplant. Type of transplant: _____ Date of procedure: _____

Member is on the transplant waiting list. List facility and type of transplant _____

Referring Provider Name: _____ Today's Date: _____

Person completing the form: _____ Office/Facility Name: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Determination of medical necessity requires the submission of documentation.

☐ Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records: _____

☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Final determination will be faxed to the prescriber. Final determination will be mailed to the member.

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim to Avera Health Plans. If you have questions about your benefits, please contact Avera Health Plans Service Center at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send a secure email to HealthServices@AveraHealthPlans.com.