VERDA HEALTHCARE - Prior Authorization Request Form for Health Care Services

Please read all instructions below before completing this form.

Verda Healthcare delegates our contracted primary care providers with the responsibility of reviewing requested services requiring prior authorization. We encourage all providers requesting services to submit prior authorization requests directly to the members' designated primary care physicians for review and determination. Based on the urgency of the requested services, Verda Healthcare may forward prior authorization requests to the members' primary care physicians for review.

Intended use of this form: The member's primary care physician is responsible for review and approval of most services. Use this form to request prior authorization for a facilities based service (eg. skilled nursing facility, ambulatory surgery center, or hospital).

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility, or other health care provider.

Additional Information and Instructions:

Section I – Submission:
Submit via fax or secure email. (Prior authorization requests may be submitted directly via HPS portal without this form.)

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- Enter the name and phone number of the primary care provider (PCP). If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: *If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the Utilization Review Agent's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

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Please submit form via: Fax (714-360-0168) OR email (VerdaPriorAuhorizations@verdahealthcare.com)

SECTION I — Submission

Issuer Name:	Phone:	Fax:	Date:

SECTION II — General Information

Review Type: __Non-Urgent __ Urgent	Clinical Reason for Urgency:	
Request Type: __Initial Request __Extension/Renewal/Amendment	Prev. Auth. #:	

SECTION III — Patient Information

Name:	Phone:	DOB:	__Male __Female __Other __Unknown
Subscriber Name (if different):	Member ID #:	Group #:	

SECTION IV — Provider Information

Requesting Provider or Facility		**Service Provider or Facility**	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — Services Requested (with CPT, CDT, or HCPCS code) and Supporting Diagnoses (with ICD code)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

__Inpatient __Outpatient __Provider Office __Observation __Home __Day Surgery __Other: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____