VILLAGECAREMAX

# PRIOR AUTHORIZATION REQUEST FORM

**Please use the fax numbers listed below for the submission of requests for prior authorizations.**

| | | | |
|---|---|---|---|
| **Inpatient Admissions** | **212-402-4468** | **LTSS: SDC, Adult Day Care, Home delivered meals, Home modifications, Auth changes or corrections.** | **646-362-2004** |
| **SNF Admissions** | **978-967-8030** | | |
| **Personal Care Services** | **646-618-8997** | **Outpatient Services** | **978-367-1872** |
| **DME** | **718-517-2709** | **Part B** | **917-243-9997** |

**This standard form should be utilized to submit prior authorization request to VCMAX along with the necessary clinical documentation to support the request. Incomplete submissions will be returned unprocessed. If you have any questions, please call 800-469-6292.**

☐**Expedited Request: Please check if you believe a delay of service could seriously jeopardize the life or health of the member or ability to regain maximum function in serious jeopardy.**

| **MEMBER INFORMATION** | |
|---|---|
| Last Name | First Name |
| Member ID | DOB |

| **PROVIDER INFORMATION** | | |
|---|---|---|
| **Check One: You are the ☐Prescribing/Ordering ☐Referring** | | |
| Name | TAX ID | NPI # |
| Provider Address | | |
| Phone | Fax | Email |
| Contact Person | Phone | Fax |
| **Check One: You are the ☐Requesting Provider ☐Servicing Provider** | | |
| Name | TAX ID | NPI # |
| Provider Address | | |
| Phone | Fax | Email |
| Contact Person | Phone | Fax |

| **CLINICAL INFORMATION** |
|---|
| Member Symptoms and Duration |
| Summary of Clinical Findings |
| Order Description |
| Medical Justification |
| Diagnosis |

| **SERVICE TYPE REQUIRING AUTHORIZATION** | | |
|---|---|---|
| Place of Service | | |
| Start Date of Service | End Date of Service | |
| Order Date | Quantity Requested | Time Requested |

| **Ambulatory/Outpatient Services** | **Inpatient Care** | **Outpatient Services** |
|---|---|---|
| ☐Surgery/Procedure | ☐Acute Inpatient Admission | ☐Physical Therapy |
| ☐Infusion or Oncology Medications | ☐Short Term/Acute Rehab | ☐Occupational Therapy |
| | ☐Skilled Nursing Facility | ☐Speech Therapy |
| **Home Health Services** | **Ancillary Services** | **Durable Medical Equipment** |
| ☐Home Health Please circle: SN,PT,ST,MSW | ☐Acupuncture | ☐Prosthetic Device |
| ☐Hospice | | ☐Enteral Supplies |
| ☐Infusion Therapy | | ☐Incontinence Supplies |
| ☐Respite Care | | ☐Medical Supplies |
| | | ☐Purchase ☐Rental |

Please attach clinical documentation to support the request. I.e. clinical notes, lab results, x-rays etc.
Durable Medical Equipment requires a physician signed prescription and letter of medical necessity.