

PRIOR AUTHORIZATION REQUEST

To get a complete list of services that require a prior authorization please visit <https://summacare.com/providers/prior-authorization>

- For **Inpatient** request please fax this form and supporting clinical to 234-542-0811
- For **Radiology, Medical Oncology, Lab & Genomic Testing** fax this form & supporting clinical to 800-540-2406, or submit online at <https://www.evicore.com>.
- **All Others** please fax this form & supporting clinical to 234-542-0815
- For **Urgent Requests ONLY**, please call 330-996-8710 option # 2 or fax to 234-542-0811

URGENT REQUESTS: Our objective is to provide appropriate & timely care to our members. An **URGENT** request is defined as:

- A medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the patient or others due to the patient's psychological state and/or
- The opinion of a Practitioner with knowledge of the patient's medical or behavioral condition, determines that without the care or treatment the patient could have adverse health consequences. SummaCare reserves the right to classify Urgent requests as standard requests when this definition is not met.
- If Urgent is not marked on this form, we will process as standard.

IN ORDER FOR THIS REQUEST TO BE PROCESSED & TO AVOID DELAYS, THIS FORM MUST BE COMPLETED IN ITS ENTIRETY ALONG WITH SUPPORTING CLINICAL ATTACHED.

☐ **URGENT** ☐ **STANDARD**

DATE: _____

MEMBER NAME _____ MEMBER ID# _____
LAST FIRST MI

MEMBER DOB _____ MEMBER'S PHONE# _____

ORDERING PHYSICIAN'S NAME _____
LAST FIRST Credentials

NPI# _____ TAX ID# _____ ADDRESS _____

PHONE# OPTION/EXT _____

DIRECT CONTACT NAME _____ PHONE# _____ FAX# _____

****Please do not give call center numbers. We need a direct person with whom we can speak with if there are further needs or questions for authorization****

***HAS THE SERVICE BEING REQUESTED ALREADY BEEN PERFORMED?** YES ☐ NO ☐

DATE(S) OF SERVICE _____ # OF SERVICES REQUESTED _____ DIAGNOSIS _____
CPT CODE(S) _____ ICD-10 DX CODE _____

☐ OUT OF NETWORK REFERRAL: REASON FOR OON REFERRAL

ALL EMERGENCY ADMISSIONS & ELECTIVE ADMITS MUST HAVE A DATE

☐ EMERGENCY ADMISSION → ☐ MEDICAL ☐ PSYCHIATRIC ☐ CHEMICAL DEPENDENCY

☐ ELECTIVE SURGICAL PROCEDURE → ☐ INPATIENT POST SURGERY REQUEST OR ☐ OUTPATIENT

☐ GENETIC TESTING ☐ IMAGING / HI TECH RADIOLOGY ☐ DME _____ ☐ PURCHASE ☐ RENT ☐ OTHER

☐ PHARMACY _____ ☐ PLEASE CHECKMARK IF YOU ARE BUYING AND BILLING

SERVICE REQUESTED ADDITIONAL NOTES

PLACE OF SERVICE –

FACILITY/PROVIDER: _____
ADDRESS _____ NPI# _____ TAX ID# _____
PHONE# _____ FAX# _____

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and privileged information for the use of the designated recipients. If you are not the intended recipient, you are hereby notified that you have received this communication in error and any review, disclosure, distribution, or copying of it or its contents is prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at 1200 E. Market St., Suite 400, Akron, OH 44305 via the USPS. If this was an email received in error, please notify the sender and delete it.

