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 ADMISSONS & 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:_____**NPI#**_____**TAX ID#**_____
ADDRESS_____**PHONE#**_____**FAX#**_____