LONGEVITY
HEALTH PLAN

REQUEST FOR PRIOR AUTHORIZATION

FAX: Form & Clinical Records to **1-855-969-5876** **CALL: 1-888-332-5941**

****Longevity Health Plan **Requires CLINICAL INFORMATION** for review of Medical Necessity along with this Prior Authorization Form. Failure to submit clinical information timely may result in an unfavorable decision. The point of contact name, phone number, and fax number are **required** to reach the provider if additional information is needed.****

FIELDS WITH AN ASTERISK (*) ARE REQUIRED

MEMBER INFORMATION (ONE MEMBER PER REQUEST FORM)

MEMBER NAME*: _____ **MEMBER DOB*:** _____

MEMBER PLAN ID*:_____ **NURSING FACILITY NAME*:**_____

DIAGNOSIS CODES (ICD-10) RELATED TO REQUEST*: _____

SERVICE REQUESTED INFORMATION

START DATE OF SERVICES*: _____

END DATE OF SERVICES (AUTHS MAY NOT BE PROVIDED FOR GREATER THAN 90 DAYS)*: _____

SERVICE CPT CODES*: _____

REQUESTING FACILITY NAME*: _____

PROVIDER NAME*: _____ **PROVIDER NPI*:** _____

PROVIDER CONTACT NUMBER*: _____**PROVIDER TIN*:** _____

QUANTITY /UNITS REQUESTED (PER CODE)*: _____

PLACE OF SERVICE CODE:_____

LEVEL OF SERVICE: ☐ Inpatient ☐ Outpatient

CONTACT INFORMATION

NAME OF PERSON COMPLETING FORM*: _____

DATE COMPLETED*:_____ **CONTACT PHONE NUMBER*:**_____

CONTACT FAX NUMBER*: _____