Tribute ADVANTAGE
(HMO-POS D-SNP)

Authorization Request Form
Attn: Intake Processing Unit
Phone: 1-833-215-9332
Fax: 1-866-439-0065

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

☐ **EXPEDITE REQUEST: By checking this box, I am stating that waiting for a decision under the standard CMS time frame (14 days) could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy**

Member Name: _____

Member Number: **AR2**_____ Date of Birth: _____ / _____ / _____

Requesting Provider Name: _____
Requesting Provider NPI#: _____ Requesting Provider Tax ID#: _____
Servicing Provider/Facility Name: _____
Servicing Provider NPI#: _____ Servicing Provider Tax ID#: _____
Contact Name:_____ Contact Phone:_____ Contact Fax:_____

Requested Service:

- ☐ Inpatient Hospital Admission
- ☐ Psychiatric Inpatient Admission
- ☐ Skilled Nursing Admission
- ☐ Partial Hospitalization
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Outpatient Diagnostic/Therapeutic Radiological Services (*no auth needed for X-rays)*
- ☐ Durable Medical Equipment/Prosthetics
- ☐ Mental Health Specialty Services
- ☐ Home Health*
- ☐ Psychiatric Services
- ☐ Out of Network Services

No auth needed for Medicare-covered Outpatient Hospital Services, Observation Services, Lab Services and Diagnostic Procedures/Tests

Service Dates: _____
ICD: _____ Dx Description: _____
Service Code 1 (HCPCS, CPT, etc.): _____ Service Code 1 Description: _____
Service Code 2: _____ Service Code 2 Description: _____

Quantity / Frequency / Duration (as applicable): _____

☐ **Clinicals are attached to support this case**

***Referral from a contracted provider is required in addition to prior authorization.**