truehealth new mexico

Prior Authorization (PA) Request Form

Fax completed form to: 1-866-446-3774
Phone number: 1-855-769-6642
*** = Required Information**

Requestor's Contact Name: _____ Requestor's Contact Number: _____

PATIENT INFORMATION

*Name: _____ *Date of Birth: _____

*Member ID Number: _____ *Member Phone Number: _____

*Service Is: ☐ **Elective/Routine** ☐ **Expedited/Urgent**

Note: Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.

(For a claim denial or prior authorization denial, please submit an appeal through Customer Service at 1-855-769-6642.)

*REFERRAL SERVICE TYPE REQUESTED

Inpatient	Outpatient	Behavioral Health	Other
☐ Surgical Procedure	☐ Surgical Procedure	☐ Inpatient	☐ Skilled Device (SN/PT/OT/SP)
☐ Elective Admission	☐ PT, OT, ST	☐ Partial Hospitalization	☐ Durable Medical Equipment
☐ Elective Observation	☐ Imaging	☐ Intensive Outpatient	☐ Dental
☐ Skilled Nursing Facility	☐ Chiropractic	☐ Chemical Dependency	☐ Experimental/Investigational
☐ Rehabilitation	☐ Acupuncture	☐ Office Visits	☐ Transportation/Transfers
☐ Long-Term Acute Care	☐ Infusion Therapy		☐ _____

PROCEDURE INFORMATION

***ICD-10** Diagnosis: _____ Diagnosis Description: _____

***CPT/HCPCS** Code and Description *(Pricing is required for injections and durable medical equipment. Include unit of measure/frequency for supplies.)*: _____

_____

* Date(s) of Service: _____ * Number of Visits: _____

PROVIDER INFORMATION

Ordering Provider: ☐ *Primary Care Physician*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Servicing Provider: ☐ *Same as Ordering*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Facility: ☐ *N/A*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Request for extension to authorization: _____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.