Prior Authorization Request Form

Please submit the completed form to AlphaCare Health Services at:
Expedited requests may be submitted electronically to Authorizations@alphacare.com or Fax: (718) 878-5173
You may also call: 1-855-OK-ALPHA (1-855-652-5742)

Request

Member Name:		Member AlphaCare ID:	
Request Type ☐ Routine ☐ Expedited ☐ Non-Contracted Provider		Documentation Attached to Support Request Includes: ☐ Clinical Notes ☐ Lab Results ☐ X-Ray Reports ☐ Other	
Does Member have other Insurance? ☐ Yes ☐ No If Yes, Name_____If yes, Group Number_____			
Diagnosis	ICD-9 code	Name of Requesting Provider	
NPI#	Address of provider	City,State, Zip	☐ Continued stay request

☐ **Initial Consultation** ☐ **Follow Up Visits** **# of Visits requested _____** **Date of Service_____**

Referral

Referred to (Servicing Provider Name):		
Address:		
City:	State:	ZIP:
NPI#	Phone #	
Specialty Type		

Location of Service(s) Requested: ☐ **Inpatient** ☐ **Outpatient** ☐ **Ambulatory Care Center** ☐ **Home Health**

Service Request

Facility Name:	
Address (City, State, Zip)	
Surgery/Procedure Description	
CPT Code(s) & Quantity (if applicable)	HCPC Code (s)
☐ **DME/Orthotics/Prosthetics Description:** ☐ **Rental** ☐ **Purchase**	
☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy** **# of Therapy Visits Requesting _____** ☐ **Transportation** ☐ **Rehabilitation** ☐ **Radiology (CT, MRI, PET)** ☐ **New Dialysis** ☐	
☐ **Behavioral Health - Psychiatric** ☐ **Behavioral Health – Substance Abuse Treatment**	

NOTE: Approval is not a guarantee of Payment. Payment is limited to Services Specified on this form and member's eligibility at time of service

Health Plan Use

☐ **APPROVED**	Date:	☐ **DENIAL**	Date:
Reference Number	Auth Expiration Date	Signature:	
Comments:			