



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 <input type="checkbox"/> Routine <input type="checkbox"/> Expedited <input type="checkbox"/> Non-Contracted Provider		Documentation Attached to Support Request Includes: <input type="checkbox"/> Clinical Notes <input type="checkbox"/> Lab Results <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Other		
	Does Member have other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name _____ If yes, Group Number _____		
	Diagnosis		ICD-9 code		Name of Requesting Provider
	NPI#	Address of provider		City, State, Zip	

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)
	<input type="checkbox"/> DME/Orthotics/Prosthetics Description: <input type="checkbox"/> Rental <input type="checkbox"/> Purchase	
	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy # of Therapy Visits Requesting _____	
	<input type="checkbox"/> Transportation <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Radiology (CT, MRI, PET) <input type="checkbox"/> New Dialysis <input type="checkbox"/>	
<input type="checkbox"/> Behavioral Health - Psychiatric <input type="checkbox"/> 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	<input type="checkbox"/> APPROVED	Date:	<input type="checkbox"/> DENIAL	Date:
	Reference Number	Auth Expiration Date	Signature:	
	Comments:			

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