Pre-Authorization Request Form

Please complete this form to request pre-authorization from VNSNY CHOICE and fax it to the contact numbers at the bottom.

Health Plan: ☐ VNSNY CHOICE Total (HMO D-SNP) ☐ CHOICE Managed Long Term Care (MLTC)	**Type of Request** (check as applicable): ☐ New request ☐ Expedited review (member faces imminent and serious threat to life or health- requires supporting clinical evidence) ☐ Written confirmation of prior oral request
Member Information	
Name (last, middle, first):	Other insurance:
Date of birth:	Other insurance policy number:
Member Insurance ID#:	Other insurance policy holder:
Gender (circle one): M or F	
PCP Name:	
Provider Information	
Requesting provider	**Servicing provider**
Name:	Name:
Address:	Address:
Tel:	Tel:
Fax:	Fax:
Contact Person:	Specialty:
NPI:	NPI:
Required Clinical Information	
Diagnosis (list codes & description)	
1.	3.
2.	4.
Procedure/service requested (list all CPT/HCPCS Codes & descriptions)	
1.	4.
2.	5.
3.	6.
For Facility Admissions only:	
Admission Type: ☐ Emergency:_____Admit date ☐ Elective: _____Anticipated admit date	Facility Type: ☐ Acute Care Hospital ☐ Long Term Acute Care ☐ Acute Rehab Facility/unit ☐ Skilled Nursing Facility
Facility Name:	Facility Phone:
Facility Fax:	Facility Address:
For Transportation Requests only:	
Type of transportation needed: ☐ Ambulance ☐ Ambulette ☐ Van ☐ Car	

For Home Health only:	
Personal Care Services: ☐ New aide placement needed ☐ Aide to restart Hours per day_____Days per week _____ Needs pick-up at hospital (i.e. no caregiver)	Home Care Services: ☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Language Pathology
Service start date:_____Service end date: _____ (If applicable)	Date of request: _____
Required Documentation	
Please attach supporting clinical information (ex: plan of care, medical records, lab reports, letter of medical necessity, progress notes, etc, as appropriate for the service(s) requested). Requests received without supporting clinical notes and required codes will not be reviewed. If this is a request for therapy, please use a separate form for each service (ex: 1 form for physical therapy with all codes and clinical info, 1 form for occupational therapy with all codes and clinical info).	

Please note the following definitions and timeframes for processing requests:

Definitions:

Expedited - member faces imminent and serious threat to life or health; requires supporting clinical evidence. Please note that we will review expedited requests to ensure they meet the criteria to be expedited. If they do not meet the criteria, the request will be processed within the standard timeframe.

Standard – all requests not meeting the expedited criteria.

Timeframes:

Medicare Advantage:

Professional services/DME - Expedited – 72 hours, Standard – 14 calendar days

Medicare Part B drug coverage- Expedited -24 hours, Standard -72 hours

MLTC: Expedited – 72 hours, Standard – 14 calendar days

Please also note that members with both a primary insurance (such as Medicare) and MLTC require a denial or explanation of benefits from the primary insurer before MLTC will cover items that are covered under both plans.

Please fax the completed form and supporting clinical information to:	
MA: 866-791-2214	MLTC: 212-897-9448

Date Form Completed and Faxed: _____

If you have any questions about your request or any claims you submitted, please contact: **1-866-783-0222.**