CENTERLIGHT Healthcare PACE

www.CenterLightHealthcare.org

Program of All-Inclusive Care for the Elderly (PACE)

Prior Authorization Request Form

Please fax this form along with any clinical documentation to our Clinical Review Department Fax #: 718-873-2890, making certain this form is completed in its entirety. For questions, please call 1-833-252-2737 (TTY 711), 8AM-8PM, M-F. Please note your request cannot be processed until we receive sufficient clinical documentation.

Date of Request: _____ Tentative Date of Service: _____

Patient Name: _____ CenterLight Member ID: _____

Request Sent By: _____ ☐ PCP ☐ Specialist ☐ DME ☐ Pharmacy

Phone Number: _____ Fax Number: _____ Email: _____

Referring Provider: _____

Are you referring to yourself? ☐ Yes ☐ No Specialty: _____

Rendering Provider Name/Facility: _____

Rendering Provider Phone Number: _____ Fax Number: _____

Rendering Provider: NPI #: _____ Tax ID #: _____

Provider's Medicare #: _____ Medicaid ID #: _____

☐ In-Network ☐ Out of Network ☐ Not Known

Place of Service Address: _____

Facility Tax ID # (if applicable): _____

Diagnosis (ICD 10 Codes): _____

Type of Service Requested: ☐ Ambulatory Surgical Procedure ☐ Inpatient Elective Admission ☐ Office ☐ Outpatient Facility ☐ Home ☐ Inpatient ☐ Other

Type of Service Requested (Description): _____

CPT/HCPCS: _____ Unit(s): _____ CPT/HCPCS: _____ Unit(s): _____

CPT/HCPCS: _____ Unit(s): _____ CPT/HCPCS: _____ Unit(s): _____

CPT/HCPCS: _____ Unit(s): _____ CPT/HCPCS: _____ Unit(s): _____

CPT/HCPCS: _____ Unit(s): _____ CPT/HCPCS: _____ Unit(s): _____

*** PLEASE ATTACH CLINICAL INFORMATION TO SUPPORT THE REVIEW FOR MEDICAL NECESSITY.
*** Failure to send necessary documentation may result in a denial due to lack of clinical information.