ASPIRUS®
HEALTH PLAN

Pre-Determination Request Form

FYI **Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request.**

Fax form and any relevant clinical documentation to: 715-787-7316

For questions, **call**: 715-631-7443 or 855-931-5265

PATIENT INFORMATION

Member Name _____ Member ID _____

Member Address _____ PMI _____

Member City, State, Zip _____ Date of Birth _____

Member Phone _____

Member Product _____(Required)

REQUIRED

Ordering Provider Name _____ ID/NPI Number _____

Ordering Provider Address _____

Ordering Provider City, State, Zip _____

Ordering Provider Phone _____ Fax _____

SERVICE PROVIDER INFORMATION

Service Provider Contact Person _____

Service Provider Name _____ ID/NPI Number _____

Service Provider Clinic Name_____NPI Number _____

Service Provider Address _____

Service Provider City, State, Zip _____

Service Provider Phone _____ Fax _____

Service Provider Email _____

Prior Authorization – Pre-Determination (continued)

ADMINISTRATIVE INFORMATION

◯ Standard Request

Standard review timeframe for an authorization decision is within **14 calendar days or 10 business days** from the date the request was received, as expeditiously as the member's health condition requires.

◯ Expedited Request

Expedited review timeframe for urgent/emergent requests within **72 hours**, as expeditiously as the member's health condition requires. Only request an expedited review if waiting the standard review timeframe would potentially jeopardize the member's health, life or ability to regain function.

Physician/Staff Name _____ Date _____

Physician/Staff Signature _____ Phone _____

Request sent by _____

Total Pages Faxed _____

Pre-Determination Request Form
(Medicare only)

SERVICE PROCEDURE/ ITEMS REQUESTED

Reason for pre-determination request (select one):

☐ Service/Procedure does not meet Original Medicare Medical Necessity Criteria

☐ Service/Procedure is not covered by Original Medicare

Procedure code(s) HCPCS or CPT: _____

Description of request

_____

_____

Relevant ICD10 code(s) _____

Diagnosis Description (include all) relevant to this request

_____

_____

Number of Units/Visits Requested_____ Frequency (if applicable) _____

Start Date Requested _____(mm/dd/yy) (required)

End Date Requested _____ (mm/dd/yy)

Place of Residence _____

CRITERIA

Confirm and complete the required steps to proceed:

☐ Clinical notes supporting any of the above have been included in the submitted information.

Notes: Please allow 14 calendar days for decision. **Submission of all relevant clinical information with the request will reduce the number of days for the decision.**