Print Form

# PRIOR APPROVAL REQUEST

HNE
HEALTH NEW ENGLAND

One Monarch Place, Suite 1500, Springfield, Massachusetts 01144-1500 • 413-787-4000 or 800-842-4464
Health Services Fax: 413-233-2700 • Managed BH Program Fax 413-233-2800
75 South Church Street, Pittsfield, MA 01201-6132
413-499-8887 • Berkshire HS Fax: 413-233-2700

**Section A. PLEASE PRINT OR TYPE. SEND COMPLETED COPIES TO HEALTH NEW ENGLAND (HNE) FOR REVIEW AND DECISION.**

Today's Date:_____ ID #: ☐☐☐☐☐☐☐☐☐ ☐☐

Patient's Name:_____

Patient's Date of Birth:_____

| **Requesting Physician Information:** | **FOR HNE USE ONLY (Eligibility Information):** |
|---|---|
| Name:_____ Provider #:_____ | |
| Address:_____ | |
| _____ | |
| _____ | |
| Contact Person:_____ Best Times:_____ | |
| Telephone:_____ Fax:_____ | |

**Section B. REQUEST DETAIL**

**Type of Request:** ☐ Inpatient Admission ☐ Surgical Day Stay ☐ Outpatient Care ☐ Non-Plan ☐ Other

**If request is for services by a non-plan provider, state why you believe services are not available in plan/network:**

_____

Please note: HNE does not verify the credentials of Non-Plan Providers; only Plan Providers go through HNE's Credentialing process.

Admitting/Specialty Physician:_____ Scheduled Admit Date:_____

Specialty:_____ Scheduled Surgical Date:_____

Address:_____ Diagnosis(es):_____

_____ ICD-9 Code(s):_____

_____ DME/Service Requested:_____

Telephone:_____ Fax:_____ _____

_____

Facility/Vendor:_____ ☐ Consultation ONLY ☐ Evaluate and Treat

Address:_____ Rationale:_____

_____ _____

**Section C. FOR HNE USE ONLY**

Inpatient/Observation Prior Approval #:_____ Outpatient Services Prior Approval #:_____

☐ Additional information needed Requested:_____ Received:_____

**HNE Decision:**

☐ Approved Total Visits Approved:_____ Approved Start Date - End Date:_____ - _____

Approval is for:_____

_____

_____

**Lab(s) Included?** ☐ Yes ☐ No **Radiology Included?** ☐ Yes ☐ No **Pre-op visits:**_____ **Post-op visits:**_____

☐ All days of this admission are approved so long as criteria for coverage are met.

☐ Inpatient Skilled Care or Rehabilitation – approved up to your benefit limit of 100 days per calendar year so long as criteria are met.

☐ Durable Medical Equipment (DME) – This approval applies to your benefit limit. Any amount over that limit is your responsibility.

☐ **For consideration of further services, please have Specialist send a written report of findings and treatment plan to HNE.**

☐ Denied (See separate letter.) Rationale:_____

_____

_____

Decision: _____ (Date) | _____ (Time) Signed:_____ PR Signature:_____

Initial Notice: _____ (Date) | _____ (Time) | _____ (Person Notified at Provider (Rendering Service) Office) | _____ (Initials) Confirmation Notice: _____ (Date) | _____ (Initials)

Prior approval is not a guarantee of payment. All payment of claims is contingent upon verification of:
(1) The member's eligibility on the date of service, (2) The medical necessity of the care, and (3) Coordination of Benefits/Subrogation status

[5/06] **PLEASE NOTE: THE REQUESTED SERVICES ARE NOT AUTHORIZED UNLESS APPROVED BY HNE IN ADVANCE OF TREATMENT.**