



GENERAL AUTHORIZATION REQUEST FORM

Please fax this form along with supporting clinical documentation to the appropriate fax number below (corresponding to the service type).

Please do not use this form for outpatient therapy or home care. Please go to the form download link to retrieve the appropriate forms for these services.

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| Medicaid/Marketplace Exchange/Essential Plan/CHP/Gold | Fax 212-908-8521/8522 | Medicare | Fax 212-908-4401 |
| Personal Care Services & Adult Day Health Care | Fax 212-908-5237 | SNF/Rehab/LTAC | Fax 212-908-3023 |
| DME Requests submit to Integra (for all LOBs except MLTC) | Fax 212-908-5185 | General Inquiries | Call 800-303-9626 |
| DME Requests for MLTC ONLY (MLTC) | Fax 212-908-5282 | Form Download Link | www.metroplus.org |
| Medicaid J-code (Physician Administered Drug) Requests ONLY | Fax 212-908-5178 | | |

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| Authorization/Tracking #: | E-Power Cert #: (if applicable) |
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| REQUEST TYPE | | |
|---|--|---|
| <input type="checkbox"/> Preauthorization: New request for services not previously approved, prior to service date | <input type="checkbox"/> Concurrent: Request for additional services for a service previously approved (ongoing care) | <input type="checkbox"/> Retrospective: Request for services already rendered without prior authorization Date(s) of Service: _____ |
| <input type="checkbox"/> Standard <ul style="list-style-type: none"> • Preauthorization = 3 business days • Concurrent = 1 business day • Retrospective = 30 calendar days | <input type="checkbox"/> Expedited: The expedited review request is subject to denial if there is no documented life-threatening condition or imminent danger to the member's health. If a request to expedite a review is denied, a determination will be made within the standard timeframe. Retrospective reviews are not eligible for expedited review. | |

| MEMBER INFORMATION | | |
|----------------------------|------|----------------|
| Name: | ID#: | Date of Birth: |
| Street Address: | | Phone Number: |
| ICD-10 Diagnosis Codes(s): | | |

| PROVIDER INFORMATION | | |
|----------------------|---------------------------------|---------------|
| Prescriber Name: | Servicing provider Name: | |
| Street Address: | Servicing provider ID#/TIN/NPI: | |
| Phone Number: | Fax Number: | Contact Name: |

| REQUESTED SERVICE INFORMATION | | | | |
|-------------------------------|--------------------|------------|-------------------------|-----------------------------|
| Code | Dose and Frequency | # of Doses | Date of Last Dose Given | Date of Next Scheduled Dose |
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| PLACE OF SERVICE | | |
|------------------------------------|---|--|
| <input type="checkbox"/> 11 Office | <input type="checkbox"/> 19 Off-Campus Outpatient | <input type="checkbox"/> 22 On Campus - Outpatient |
| <input type="checkbox"/> 12 Home | <input type="checkbox"/> Other _____ | |