Martin's Point

# Outpatient Authorization Request Form Guidelines

## Preauthorization requests (PRESERVICE)

### *For Martin's Point Generations Advantage and US Family Health Plan:*

- Not required for emergency care
- Should be submitted at least two weeks prior to the date of service or facility admission
- **If the servicing provider is not part of the Martin's Point Generations Advantage or US Family Health Plan network, submit this form with a letter of medical necessity (including clinical documentation) explaining why the service(s) can only be provided by this specialist.**
- For mental health/substance abuse services call Behavioral Health Care Program (BHCP) at 1-888-812-7335.
- For Part D drug preauthorization, visit **https://martinspoint.org/for-providers/resources/pharmacy.**
- For more information, visit **https://martinspoint.org/for-providers/tools/authorizations.**

## Retrospective authorization requests (POSTSERVICE)

***US Family Health Plan:*** We will review retrospective authorization requests for all qualified care, before or after claim submission. Participating and nonparticipating providers may use this form. Determinations will be made within 30 calendar days of the date of form receipt.

***Generations Advantage:*** We will review retrospective authorization requests only under the following circumstances:

- **Urgent/Emergent:** Requests for medical treatment required in order to prevent death or serious impairment of health, or medical treatment needed for an illness or injury that is not immediately life-threatening but requires professional medical attention to prevent a serious risk to the member's health.
- **Unable to Know:** When the provider did not have, and was unable to obtain, the patient's insurance information pre-service (i.e., unresponsive patient delivered to an emergency room).
- **Not Enough Time:** When the patient requires immediate or very near-term medical services (typically related to a service already being performed). For example, during a procedure, the provider identifies an acute need for hospital admission or, the procedure that evolves into a different/ additional procedure which is performed immediately or scheduled for the same day.

**Please read the complete definitions of these exception criteria before submitting a retrospective authorization request.**

- **Participating providers** seeking retrospective authorization for a Generations Advantage member must file a claim for that service, wait for claim denial, and then submit a **Generations Advantage Authorization Dispute Form (PDF). If your situation meets one of the above criteria, please submit a Generations Advantage Authorization Dispute Form (PDF) with documentation that supports the "Urgent/Emergent," "Unable to Know" or "Not Enough Time" exception. We will first assess the criteria for coverage and then for medical necessity.**
- **Non-participating providers** seeking retrospective authorization for a Generations Advantage member must file a claim for that service, wait for claim denial and then initiate the **claim appeal process** on behalf of the member. We cannot begin the appeal process without a signed **Waiver of Liability Form (PDF)** and **Medicare Appointment of Representative Form (PDF).**

# Form submission instructions:

- **All fields are required.** Incomplete forms cannot be processed. Please include supporting clinical documentation.
- For **outpatient** authorization requests, please fax the completed form to **1-207-828-7865.**
- Or, call **1-888-339-7982,** 8 am to 4:30 pm, weekdays for inpatient or outpatient authorization requests.
- Please do not resubmit authorization requests unless you are specifically requested to do so by Martin's Point.
- To check the status of a request visit **https://Providers.MartinsPoint.org/Tools/Authorizations** or call **1-888-339-7982.**
- Authorization requests and approvals are not a guarantee of payment.

Martin's Point

# Outpatient Authorization Request Form

Health Plan: ☐ US Family Health Plan ☐ Generations Advantage Today's Date: _____

☐ **MEDICALLY URGENT PER PHYSICIAN:** By checking this box, you are acknowledging that this request is for immediate medical treatment required to prevent death or serious impairment of health or medical treatment needed for an illness or injury that is not immediately life-threatening but requires professional medical attention that should be treated generally within 24 hours before it becomes a serious risk to the member's health. If appropriate clinical criteria are demonstrated, these determinations will be made as expeditiously as the member's health condition requires. **Appropriate clinical documentation is required to support need for urgent review**.

## Member

Last Name: _____ First Name: _____

DOB: _____ Policy #: _____ Actual/Anticipated Inpatient Admit Date: _____

## Ordering provider

Last Name: _____ First Name: _____

NPI#: _____

Mailing Address: _____

## Contact information

Contact Name: _____ Phone: _____ Fax: _____

## Servicing provider ☐ Same as Ordering Provider

Last Name: _____ First Name: _____

Provider NPI#: _____ Specialty: _____

Practice Name: _____

Practice NPI#: _____ Practice Tax ID #: _____

Physical Address: _____

Mailing Address (if different from physical address): _____

Phone: _____ Fax: _____

## Servicing facility

Name: _____

NPI#: _____ Tax ID #: _____

Physical Address: _____

Mailing Address (if different from physical address): _____

Phone: _____ Fax: _____

## Requested service

- ☐ ABA Services
- ☐ Ambulance (Air/Ground)
- ☐ Chiropractic
- ☐ Clinical Trial
- ☐ Diagnostic Outpatient
- ☐ Dialysis
- ☐ Durable Medical Equipement
  - ☐ Rental ☐ Purchase
- ☐ Genetic Testing
- ☐ Hospice
  - ☐ GIP ☐ Routine ☐ Respite
- ☐ Infusion Services
  - ☐ Outpatient ☐ Home
- ☐ Medical Nutrition Therapy/ Counseling
- ☐ Office Visit/Consult
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Surgical
- ☐ Pharmaceutical
- ☐ Radiation Therapy
- ☐ Transplant/Evaluation
- ☐ Wound Care

ICD Diagnosis Codes: _____

CPT/HCPC Codes: _____ Requested Number of _____ ☐ visits / ☐ months / ☐ units.

**Fax completed form to 1-207-828-7857 INCLUDING SUPPORTING CLINICAL DOCUMENTATION**
**DO NOT REQUEST INPATIENT SERVICES USING THIS FORM.**