HNE
HEALTH NEW ENGLAND

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# PRIOR APPROVAL REQUEST

## MEMBER INFORMATION

**DIAGNOSIS(ES)**

Today's Date:_____/_____/_____ _____

Name:_____ _____

**Date of Birth:**_____/_____/_____ _____

ID#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

## REQUESTING PHYSICIAN

Name:_____ Provider #: _____

Address:_____

_____

**Name & Direct # to Person Completing Form:**

_____

## CHOOSE YOUR REQUEST TYPE:

### ❑ HOSPITALIZATIONS

___Inpatient Admission ___Surgical Day ___Observation

Admit Date:_____/_____/_____

Procedure/CPT Code(s):_____

_____

**Admitting Physician:** _____

Address:_____

_____

Phone:_____ Fax:_____

**Facility:**_____

Address:_____

_____

Phone:_____ Fax:_____

___ In-plan ___ Out-of-Plan _____ # of Pre-Op _____ # of Post-Op

### ❑ DURABLE MEDICAL EQUIPMENT

**Provider:**_____ **Provider #**_____

Address:_____

_____

Phone:_____ Fax: _____

HCPC _____ # of Units _____

HCPC _____ # of Units _____

HCPC _____ # of Units _____

HCPC _____ # of Units _____

Prescribing Physician:_____

Phone:_____

Orders:_____

___ Out-of-Plan

Rationale for utilizing an out-of-plan provider:

_____

### ❑ OUT-OF-PLAN OUTPATIENT SERVICES – Please note: HNE does not verify the credentials of Non-Plan Providers. Any Imaging services (MRI, CT, PET) must be performed in-plan.

___ Second Opinion Only: Submit office notes from the in-plan treating specialist related to request

___ Evaluation: Submit office notes from the in-plan treating specialist related to request

___ Follow-Up: Submit office note from the last visit.

___ Student/Travel: Submit any pertinent documentation.

Rationale: _____

_____

Member's in-plan treating specialist:_____

Physician Requested:_____

Specialty:_____

Address:_____

_____

Phone:_____ Fax:_____

Procedure Name:_____

CPT Codes:_____

_____

_____

Date of Visit: _____/_____/_____ _____ # of Visits

Comments:_____

_____

_____

### ❑ IN-PLAN OUTPATIENT SERVICES

Provider:_____ Provider #:_____

Specialty:_____

Address:_____

_____

Phone:_____ Fax:_____

**Service/CPTCode(s):**_____

❑ In office

❑ Other: _____

PLASTIC SURGEONS ONLY: Will this be the only surgery being performed?

❑ YES or ❑ NO

10001HS

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. For information regarding timeframes please contact the Health Services Department at 413-787-4000 or 800-842-4464, extension 5027.