Acentra HEALTH

Prior Authorization Request Form – Confidential

Please complete this form in its entirety. Fax completed form, along with all necessary clinical information to support medical necessity review request to Acentra Health at 512- 975-7642. You may also request a prior authorization (PA) by contacting Acentra Health's Customer Service Department at 800-634-4832.

Request Type (Select One) ☐Concurrent ☐Prior Authorization ☐Retrospective
Date of Request: ______________________________________

Provider Information

Requesting/Ordering/Referring Provider Name: ________________
Requesting Provider NPI:___________________________________
Servicing Provider Name: _________________________________
Servicing Provider NPI: ___________________________________
Contact Person Name:_____________________________________
Contact Person Phone Number: Fax:

Participant Information

First Name: ____
Last Name: ____
Participant ID: ____
Date of Birth: ____
Phone Number: ____
Email Address:

Service Type: Select either Outpatient or Inpatient and the applicable service type below; Inpatient must include Length of Stay (LOS) start and end dates

☐ **Outpatient**

Select applicable service type below

Reminder: Procedure codes must be provided on Page 2 for Outpatient procedures

☐Home Health ☐Therapies (OT, PT, ST)
☐Home IV Therapy ☐Total Parenteral Nutrition
☐Intravenous Immunoglobin (IVIG)
☐Surgical Procedure ☐Pain Management
☐Gender Reassignment ☐Nutritional Counseling
☐Clinical Trials ☐Miscellaneous Services

☐ **Inpatient**

Enter LOS and select applicable service type below

LOS Start Date:
LOS End Date:

☐Inpatient Hospital ☐Skilled Nursing Services
☐LTAC ☐Inpatient Rehab ☐Gender Reassignment
☐Transplant ☐Inpatient BH Admission
☐Inpatient SA Admission ☐BH Residential Treatment Facility
☐SA Residential Treatment Facility
☐BH Partial Hospitalization ☐SA Partial Hospitalization
☐Halfway Housing ☐Group Home
☐Intensive Outpatient (IOP BH or SU)

Diagnosis ☐Mark *Primary Diagnosis, use additional pages as necessary*

Primary	Diagnosis Code	Primary	Diagnosis Code
☐		☐	

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Services Requested *Use additional pages as necessary*

Modifier	Procedure Code	Requested Start Date	Requested End Date	Requested Quantity
Modifier	Procedure Code	Requested Start Date	Requested End Date	Requested Quantity

Additional Comments or Information