



CARE IMPROVEMENT PLUS

Specialized care for Medicare beneficiaries

Preauthorization Line 1-888-625-2204
Hours of Operation: 8:30 am – 5:00 pm

Submission Date: ____/____/____

Provider Request Form

Care Improvement Plus Member Information

Last Name: _____ First Name: _____ Middle Initial _____

SUBSCRIBER ID# _____ Date of Birth _____

Medicaid # (if applicable): _____ Other Insurance Name/Policy #: _____

If Inpatient, admitting from: ER Home SNF LTACH IRF Hospice Acute Hospital LTC or ALF

Service Provider Service Start Date: ____/____/____ Service End Date: ____/____/____

Provider/Vendor Name: _____ Tax ID#: _____

Contact Name: _____ Phone Number: _____ ext. _____ Fax# _____

Provider/Vendor Address: _____

Ordering Physician: _____ Phone Number: _____ Fax# _____

ICD9 Codes/Description: _____ CPT/HCPCS Codes _____ ; _____

Service Type – please check the type of service you are requesting and submit the supporting documentation with this form. *See Fax numbers for each state below.

Inpatient Hospital Admission Emergent

Please notify us within 1 business day of all emergency admissions.

Elective Hospital Services

Please submit requests at least 14 calendar days prior to the scheduled procedure for the services below:

- * Blepharoplasty
- * Bariatric Procedures (weight loss)
- * LVAD
- * Organ and Bone Marrow Transplants: Ph:1-866-460-8699 option 4 or Fax: 443-853-2771

Long Term Acute Hospital (LTACH)

Skilled Nursing (SNF)
 Inpatient Rehab (IRF)

Please fax the physician's order, physical, occupational and speech therapy evaluations and/or skilled nursing orders for treatments such as IV antibiotic orders, wound care orders, etc.

Durable Medical Equipment Request

Please refer to your **Provider Fact Sheet** for the specific information that is needed for the selected DME below:

- * Power Wheelchairs
- * Power Operated Vehicles
- * Wound Vac
- * Lymphedema Pump
- * Lower Limb Prosthesis
- * Bone Growth Stimulators
- * Spinal Cord Stimulator (Pain Management)
- * Air Fluidized Beds (in home)

Home Health

Once the care has been initiated, within the first week, please submit:

- The Doctor's order or 485 Plan of Care
- Nursing/Therapy assessment
- Progress notes

When requesting on-going episodes of care please:

- Fax the nursing/therapy progress notes,
- Current 485 Plan of Care,
- Signed 485 Plan of Care from previous episode,
- The face to face evaluation completed in the past 60 days.

This should be submitted within 72 hours of expiration of the current episode.

Please fax completed form for the below services to:

HOME HEALTH 1-866-219-2923
 SNF, LTACH, IRF 1-866-304-2382
 INPATIENT HOSP 1-800-211-6490
 DME 1-866-224-1151

Authorization is based on a determination that services are medically necessary but is not a guarantee of payment. Payment for services is subject to member eligibility and benefits limitations.