



CARE IMPROVEMENT PLUS

Specialized care for Medicare beneficiaries

Preauthorization Line 1-888-625-2204

Hours of Operation: 8:30 am – 6:00 pm EST

Missouri Preauthorization Request Form

Submission Date: ___/___/___

Care Improvement Plus Member Information

Last Name: _____ First Name: _____ Middle Initial _____

SUBSCRIBER ID# _____ Date of Birth _____

Medicaid # (if applicable): _____

Other Insurance Name: _____ Policy #: _____

Service Provider *Service Start Date: ___/___/___ Service End Date: ___/___/___*

Company Name: _____ Tax ID#: _____

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

Company Address: _____

Ordering Physician: _____ Phone Number: _____ Fax# _____

ICD9 Codes: _____; _____; _____ HCPCS Codes _____; _____; _____

Service Type – please check the type of service you are requesting and submit the supporting documentation with this form

Inpatient Hospital Admission (elective or emergent) please provide the name and TAX ID of your facility, attending physician's name, member's name and subscriber ID number, diagnosis (words), diagnosis codes, date of admission, date of discharge (if applicable).

Transplants, Blepharoplasty and Bariatric procedures (inpatient or outpatient) require prior authorization.
Fax: 866-276-1717

Transplants: Phone 1-866-460-8699 option 4 x 7601, Fax: 443-524-8734

Long Term Acute Care Admission
 Skilled Nursing Facility Admission
 Acute/Comprehensive Inpatient Rehab Admission- please provide the name and TAX ID of your facility, requesting physician's name, member's name and subscriber ID number, diagnosis (words), diagnosis codes, date of admission, physical, occupational and speech evaluations if the member is to receive rehabilitation and the skilled nursing orders (i.e. iv abx, wound care, etc.)

Fax: 866-276-1004

Durable Medical Equipment Request- please provide the name and TAX ID of your facility, requesting physician's name, member's name and subscriber ID number, diagnosis (words), diagnosis codes, physical and occupational evaluations for power operated vehicle requests. Please see our **Provider Fact Sheet** for the specific information that is needed for DME requests.

Fax: 866-276-8580

Home Health Request- please provide the name and TAX ID of your facility, requesting physician's name, member's name and subscriber ID number, diagnosis (words), diagnosis codes, start of care, physical, occupational and speech evaluations if the member is to receive rehabilitation and the skilled nursing orders (i.e. iv abx, wound care, monitoring, teaching, etc.)

Fax: 866-224-2117