CARE IMPROVEMENT PLUS

Specialized care for Medicare beneficiaries

Preauthorization Line 1-888-625-2204
Hours of Operation: 8:30 am – 6:00 pm EST

Texas 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). Blepharoplasty and Bariatric procedures (inpatient or outpatient) require prior authorization. **Fax: 866-217-8911** **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: 866-447-7354**	☐ **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: 866-460-8665**	☐ **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: 866-447-7863**