Tribute Health Plans

Authorization Request Form
Attn: Intake Processing Unit
Phone: 1-844-857-1601
Fax: 1-800-413-8347

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

☐ EXPEDITE REQUEST: **By checking this box, I am stating that waiting for a decision under the standard CMS time frame (14 days) could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy**

Member Name: _____

Member Number: **AR**_____ Date of Birth: _____ / _____ / _____

Requesting Provider: _____

Servicing Provider: _____

Contact Name: _____

Contact Phone: _____ Contact Fax: _____

Requested Service:

- ☐ Inpatient Hospital Admission
- ☐ Psychiatric Inpatient Admission
- ☐ Skilled Nursing Admission†
- ☐ Partial Hospitalization*
- ☐ Physical Therapy†
- ☐ Occupational Therapy†
- ☐ Speech Therapy†
- ☐ Durable Medical Equipment / Prosthetics
- ☐ Ambulatory / Outpatient Surgery
- ☐ Outpatient Observation
- ☐ Home Health*
- ☐ Telehealth Services*
- ☐ Dialysis Services*
- ☐ Out of Network Services
- ☐ Medicare Part B Drug

Service Dates: _____

ICD: _____ Dx Description: _____

Service Code 1 (HCPCS, CPT, etc.): _____ Service Code 1 Description: _____

Service Code 2: _____ Service Code 2 Description: _____

Quantity / Frequency / Duration (as applicable): _____

All supporting information must be supplied with clinical documentation attached before a consideration will be made.

***Referral from a contracted provider is required in addition to prior authorization.**
†Authorization not required for facilities under alternative payment / value based / bundled payment arrangements.