AUTHORIZATION REQUEST FORM

General Rules

- **Urgent and Emergency Care DO NOT require Prior Authorization.**
- **Excluded services are not covered. Excluded services will be denied as a non–covered benefit, per the Member's Evidence of Coverage (EOC).**
- **Providers are responsible for verifying eligibility and benefits before providing services to all members. Prior Authorization is not a guarantee of payment for services.**
- **Payment is made in accordance with a determination of the member's eligibility, benefit limitations/exclusions, evidence of medical necessity during the claim review and provider status.**
- **Failure to obtain Prior Authorization prior to giving care for the services listed below may result in a denial for reimbursement.**
- **Services not requiring Prior Authorization will be subject to audit. If in an audit those services did not meet medical necessity, there will be a possibility of recoupment.**
- **If clinical documentation supporting claims are not provided, Hamaspik may deny for not having the information required to determine medical necessity.**
- **If a member is admitted to your facility, you must notify Hamaspik within 24 hours.**
- **Non-Participating (Out of Network Providers) require out-of-network authorization (OON approval) prior to providing any services, except for Urgent and Emergency Services.**
- **Any service that is being performed in a hospital setting requires a prior authorization.**
- **Please refer to the Hamaspik Medicare provider manual on our website www.hamaspik.com; General Requirements for Claims Submissions.**

Please send completed form, prescription from referring provider, and supporting clinical documentation pertaining to this requestto: MedicareRequests@hamaspikchoice.org; Fax: 845-503-1911

If you have questions or updates regarding your request, please contact us at 1-888-426-2774 x608.

The following time frame standards apply to all services requiring prior authorization:

- **Elective Services** - 14 days prior to the scheduled elective service. If contact cannot be made 14 days prior to the scheduled service, it should be made as soon as medically possible prior to the scheduled service.
- **Urgent Services** –Prior to urgent services being rendered. If contact cannot be made prior to an urgent service, then contact must occur within one business day of the service.
- **Emergent Services** - Notification within one business day of emergent services.

Thank you,

Hamaspik Medicare Utilization Management Dept.
HamaspikMedicare
Direct Phone: 888-426-2774 x608
Direct Fax: 845-503-1911
Email: medicarerequests@hamaspikchoice.org
Web: www.hamaspik.com

Hamaspik Inc.

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SERVICES REQUIRING PRIOR AUTHORIZATION	Utilization Review Information
Acupuncture Services	American Specialty Health Fax: 1-877-427-4777; Phone: (800)-848-3555 or (800)972-4226 https://www.ashlink.com/ASH/site/authentication/login.aspx?ReturnUrl=%2fASH
All Inpatient Admissions (including inpatient, long-term acute hospital, Mental Health, Acute Rehab, Sub-acute/Short-Term Rehabilitation, Skilled Nursing Facility) and Hospital Observation Stays	Behavioral: Beacon Health Options 866-201-1401 Medical: Hamaspik Utilization Mgmt. Email: MedicareRequests@hamaspikchoice.org; Fax: (845)503-1911; Phone: (888) 426-2774 x 608
Dental Services (Submit to DentaQuest)	DENTAQUEST: Fax: (262)241-7150; Phone: (855) 343-4267 Email: denelig.benefits@dentaquest.com
Vision Services (Optometry - Submit to EyeQuest)	EYEQUEST: Fax: (888)696-9552; Phone: (844) 824-2014 Email: eyequest@dentaquest.com
Durable Medical Equipment (DME) and Prosthetics including all DME rental	Hamaspik DME Dept. Fax: (845)503-1511; Phone: (888)426-2774 x612 Email: dme@hamaspikchoice.org
All non-emergent transport including Ambulance and Air Ambulance	Hamaspik Transportation Dept. Fax: (845) 503-1998; Phone: (888) 426-2774 x615 Email: transportation@hamaspikchoice.org
Chiropractic Services	Hamaspik UM until 8/31/22 American Specialty Health 9/1/22
All Experimental/Investigational Services	Hamaspik Utilization Mgmt. Email: MedicareRequests@hamaspikchoice.org; Fax: (845)503-1911; Phone: (888) 426-2774 x 608
All Out-of-Network Services (OON) and referrals	
[illegible]	
Any scheduled service that is being performed in a hospital setting	
Cardiac Rehabilitation, Pulmonary Rehabilitation and Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	
Diagnostic Tests Procedures -- Authorization is required for certain diagnostic procedures, non-lab tests and genetic testing procedures, MRA, MRI, PET Scans. Routine lab tests do not require prior authorization.	
Enteral and Total Parenteral Nutrition	
Home Health Therapies /CHHA Services: Physical, Occupational, Speech Therapies, Social Work, Registered Nurse, Home Health Aide Services	
Hyperbaric Oxygen Therapy	
MAP Plan Only Long-term Care Services including: Registered Nurse/ Private Duty Nursing/PDN, Adult Day Care*, Social Day Care*, Personal Care Assistance Services*, Consumer Directed Personal Assistance Services*	
Medical Nutritional Therapy	
Nuclear Medicine	
Organ Transplants/ Evaluations	
Outpatient Therapies	
Pain Management	
Radiation Therapy	
Radiology	
Sleep Studies	
Specialty Prescriptions may require Prior Auth, Step-therapy, or have quantity limits as per Formulary	MagellanRX (complete PA form on www.hamaspik.com) FAX: 1-800-424-3260; Phone: (800)424-4437 -Coverage Determinations; Helpdesk (800)933-3175

Authorization Request Form must be submitted with prescription from referring Provider for all services requiring Prior Authorization

Some Services Require additional forms to be completed (i.e., Social/Adult Day Care, PCA, CDPAS). Please visit www.hamaspik.com for required forms.

Visits to in-network Primary Care Physicians and Specialists (including ophthalmologists do not require Prior Authorizations) .

AUTHORIZATION REQUEST FORM

Member Details	Submitter Details	Where would you like for us to send the determination to? EMAIL ☐ FAX ☐ MAIL ☐
Name:	Submitted by:	ADDRESS:
Date Of Birth:	Date:	
Member HC ID:	Time Submitted:	
Primary DX:	Email:	
Last Exam Date:	Fax:	

Request Type	Frequency	Specifics (Type/Units/ Visits)

Authorization /Service Request Additional Details *(include reason for admission/services)*:

ICD-10(s):	CPT(s) (Include Modifiers):	HCPC(s) (include Modifiers):
Service(s) Start Date:	Service(s) End date: *(As Applicable)*	

Please attach prescription, clinical documentation, and details, as relevant.

Referring Provider Details			Servicing Provider Information *(Provider rendering the service)*		
Referring Provider Information Name:			Servicing Provider Name: *(Specify Doing Business As (DBA) Name as applicable)*		
Referring Provider Type:		NPI:	Servicing Provider Type:		NPI:
Individual Provider	☐	TIN:	Individual Provider	☐	TIN:
Group	☐		Group	☐	
Hospital	☐		Hospital	☐	
Short-Term | Subacute Rehabilitation	☐	Address:	Short-Term | Subacute Rehabilitation	☐	Address:
Long-Term Skilled Nursing Facility Care	☐		Long-Term Skilled Nursing Facility Care	☐	
DME	☐	Phone:	DME	☐	Phone:
Home Health Agency (HHA|CHHA)	☐	Email:	Home Health Agency (HHA|CHHA)	☐	Email:
Specialty Provider	☐	Fax:	Specialty Provider	☐	Fax:
Other (specify):			Other (specify):		

Referring Provider Signature (REQUIRED):

Place of Service Details: (*if different from requesting provider; service provider information)*	
In example, if a member is in the hospital requesting a surgery, provider who will conduct surgery will be different than the place of service (hospital)	
Facility:	Phone (include ext.):
Address:	Email:
NPI:	Fax:
TIN:	Other:

PLEASE SEND THIS FORM TO: MedicareRequests@hamaspikchoice.org; Fax: 845-503-1911

Office Use Only *Date |Time Received:*