AUTHORIZATION REQUEST FORM

General Rules

- **Non-Participating (Out of Network Providers) require out-of-network authorization (OON approval) prior to providing any services, except for Urgent and Emergency Services.**
- **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.**
- **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

AUTHORIZATION REQUEST FORM

Hamaspik Inc.

<table>
<tr><th>SERVICES REQUIRING PRIOR AUTHORIZATION</th><th>Utilization Review Information</th></tr>
<tr><td>Acupuncture Services</td><td>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</td></tr>
<tr><td>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</td><td>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</td></tr>
<tr><td>Dental Services (Submit to DentaQuest)</td><td>DENTAQUEST:
Fax: (262)241-7150; Phone: (855) 343-4267
Email: denelig.benefits@dentaquest.com</td></tr>
<tr><td>Vision Services (Optometry - Submit to EyeQuest)</td><td>EYEQUEST:
Fax: (888)696-9552; Phone: (844) 824-2014
Email: eyequest@dentaquest.com</td></tr>
<tr><td>Durable Medical Equipment (DME) and Prosthetics including all DME rental</td><td>Hamaspik DME Dept.
Fax: (845)503-1511; Phone: (888)426-2774 x612
Email: dme@hamaspikchoice.org</td></tr>
<tr><td>All non-emergent transport including Ambulance and Air Ambulance</td><td>Hamaspik Transportation Dept.
Fax: (845) 503-1998; Phone: (888) 426-2774 x615
Email: transportation@hamaspikchoice.org</td></tr>
<tr><td>Chiropractic Services</td><td>Hamaspik UM until 8/31/22
American Specialty Health 9/1/22</td></tr>
<tr><td>All Experimental/Investigational Services</td><td rowspan="20">Hamaspik Utilization Mgmt.
Email: MedicareRequests@hamaspikchoice.org;
Fax: (845)503-1911; Phone: (888) 426-2774 x 608</td></tr>
<tr><td>All Out-of-Network Services (OON) and referrals</td></tr>
<tr><td>! ff {dzǋƎŜǋʎŜăк tǋƻŎŜŘdzǋŜăк¢ŜăǘʎyƎ øKŜyƳǈŜǋƮƻǋYƳŜŘ ʎyƳ l·yƳLyǈl·ǘʎŜyǘ hdzǘǈl·ǘʎŜyǘ Ʈl·ŎʎƒǘʎŜă l·yŘ ăŜƒŜŎǘ ƻƮƮʎŎŜ ǈǋƻŎŜŘdzǋŜăY !ŘØl·yŎŜŘ wl·ŘʎƻƒƻƎè ǿʎyŎƒdzŘʎyƎ ydzŎƒŜl·ǋ YƳŜŘʎŎʎyŜǘ a h I { {dzǋƎŜǋʎŜă 9yŘƻăŎƻǈʎŜăк/ƻƒƻyƻăŎƻǈʎŜă ǿƻǘKŜǋ ǘKl·yƳăŎǋŜŜyʎyƎ ŎƻƒƻyƻăŎƻǈʎŜăǘ .dzyʎƻyŜŎǘƻYƳʎŜă [l·ăŜǋ {dzǋƎŜǋè, Varicose Vein(s)</td></tr>
<tr><td>Any scheduled service that is being performed in a hospital setting</td></tr>
<tr><td>Cardiac Rehabilitation, Pulmonary Rehabilitation and Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services</td></tr>
<tr><td>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.</td></tr>
<tr><td>Enteral and Total Parenteral Nutrition</td></tr>
<tr><td>Home Health Therapies /CHHA Services:
Physical, Occupational, Speech Therapies, Social Work, Registered Nurse, Home Health Aide Services</td></tr>
<tr><td>Hyperbaric Oxygen Therapy</td></tr>
<tr><td>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*, Hearing Aides</td></tr>
<tr><td>Medical Nutritional Therapy</td></tr>
<tr><td>Nuclear Medicine</td></tr>
<tr><td>Organ Transplants/ Evaluations</td></tr>
<tr><td>Outpatient Therapies</td></tr>
<tr><td>Pain Management</td></tr>
<tr><td>Radiation Therapy</td></tr>
<tr><td>Radiology</td></tr>
<tr><td>Sleep Studies</td></tr>
<tr><td>Specialty Prescriptions may require Prior Auth, Step-therapy, or have quantity limits as per Formulary</td><td>MagellanRX (complete PA form on www.hamaspik.com)
FAX: 1-800-424-3260;
Phone: (800)424-4437 -Coverage Determinations;
Helpdesk (800)933-3175</td></tr>
</table>

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) .

Hamaspik Inc.

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 - Specify Type Of Request	Frequency	Specifics (Type/Units/ Visits)

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

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: Group NPI:	Servicing Provider Type:		NPI: Group NPI:
Individual Provider			Individual Provider		
Group		TIN:	Group		TIN:
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:*