

El Paso Health Medicare Advantage Dual (HMO D-SNP)
Pre-authorization Fax Form
Fax: 915-298-7866 / UM Dept. 1-915 532-3778 ext. 1500 Toll Free
1-833-742-3125

NOTE: Prior authorization is based on information provided to El Paso Health Medicare Advantage Dual (HMO D-SNP) at the time of request, it does not guarantee payment of benefits nor verify eligibility and is subject to all terms, conditions, limitations, and exclusions related to the member's eligibility and subsequent medical review. Regardless of prior-authorization status, medical decisions concerning a course of treatment are solely between the physician and the patient.

CIRCLE ONE:	NEW REQUEST	ADDITIONAL INFORMATION	AMENDMENT	REFERENCE #:	Include Reference No. & Additional Info for all Amendment requests
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Requesting Provider, Facility or Representative					
Date of Request: _____	Provider Name: _____	NPI #: _____			
Contact Person: _____	Phone #: _____	Fax #: _____			
Place of Service: _____	Request Type: <input type="checkbox"/> Standard		<input type="checkbox"/> Expedited (Urgent)		

Patient Information					
Member Name: _____	DOB: _____	Member ID: _____			
Phone #: _____	Mobile #: _____	Emergency Contact: _____		Phone #: _____	

Service Provider or Facility					
Name: _____	Contact Person: _____	Phone #: _____			
NPI #: _____	Specialty: _____	Fax #: _____			
Place of Service: _____	Address: _____				

Services Requested					
Check One:	<input type="checkbox"/> Inpatient Services	<input type="checkbox"/> Office Treatment	<input type="checkbox"/> Observation	<input type="checkbox"/> Outpatient Services	<input type="checkbox"/> Behavioral Services
<input type="checkbox"/> DME	<input type="checkbox"/> Home Health	<input type="checkbox"/> Hospice	<input type="checkbox"/> Other (Describe Services): _____		
Therapy (Circle One):	<input type="checkbox"/> ST	<input type="checkbox"/> PT	<input type="checkbox"/> OT	Number of Sessions: _____	Duration: _____

EXPECTED DATE OF PROCEDURE: _____	Start Date: _____	End Date: _____		
ICD-10 Code	CPT Code	Units/Encounters	CPT Code	Units/Encounters
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

To avoid delay with your requests, submit all pertinent clinical information along with the prior authorization request form.
Submit any additional documentation