PHYSICAL MEDICINE RETRO AUTHORIZATION REQUEST

CONTACT / REQUESTOR INFORMATION:

Contact Name____ Phone #________________________ Ext___________

HP / MEMBER INFORMATION:

Health Plan Name HMSA________________________ Member ID ____

Member Last Name ______________________First Name _______________________________DOB_______________

TREATING PROVIDER INFORMATION:

Treating Provider Name ____

Treating Provider Address____

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Treating Provider Phone ___________________________________ Fax ______________________________________

Treating Provider TIN____ NPI ______________________________________

PLACE OF SERVICE INFORMATION:

RETRO DATES OF SERVICE: ____ # **VISITS:** __________________

REASON FOR REQUEST OUTSIDE THE 10-BUSINESS DAY GRACE PERIOD:

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CAUSE OF THERAPY:

DISCIPLINE TYPE:

Initial Evaluation Date _________________________________ Primary ICD 10 Dx code ___________________________

Other ICD 10 Dx Codes ____

CLINIC INFORMATION:

Treating Provider/Clinic Name ____

Address____

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Clinic TID _________________________Clinic NPI ___________________________Phone___________________________

Email completed form via SECURE email to: HMSAProviderConcerns@Evolent.com

IMPORTANT: Please attach clinical documentation to RadMD case once created