



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 _____

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:

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 _____

Clinic TID _____ Clinic NPI _____ Phone _____

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

IMPORTANT: Please include supporting clinical documentation with this request form.