Population Health Authorization Request Form

Please fax, email or mail completed form to Utilization Management for processing.



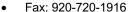
- Fax: 920-720-1916
- Secure Email: pophealthutiliza@networkhealth.com
- Mail: Network Health, Attn: Utilization Management Department, 1570 Midway Pl., Menasha, WI 54952
- Requests can be completed online via our Provider Portal iExchange at https://login.networkhealth.com

Request must include related records that support the medical necessity of service(s): notes, labs, diagnostics, plan of care, etc. Requests received without records may be sent back or denied for information.

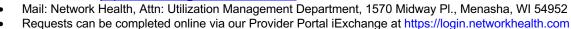
Today's Date:			
Form Filled Out By:	Contact Phone:		Contact Fax:
Section A: Patient Information			
Member Name:		Member ID#:	
Date of Birth:		Plan: ☐ Medicare ☐	Commercial/ACA ☐ TPA (Exceedent)
Section B: Request Type			
☐ Urgent (state reason why):			
Inpatient Admission:	Behavioral Hea	lth/AODA:	☐ Durable Medical Equipment
☐ Acute/ER☐ Transplant	☐ Inpatient☐ Residential		☐ Home Health Care
☐ Planned/Scheduled☐ Rehabilitation	☐ Outpatient☐ Intensive Out	rationt	☐ Other:
☐ Skilled Nursing Facility	☐ Partial Hospit	•	
☐ Long Term Acute Care			
Section C: Service Information			
CPT (Procedure) Code(s): Additionally, please complete section F for DME and complete section G for home health requests.			
ICD-10 (Diagnosis) Code(s):	· · · · · · · · · · · · · · · · · · ·		
Start Date of Service: End Date of Service:			
Number of initial sessions requested: If applies, number of additional sessions requested:			
New episode of care? ☐ Yes ☐ No If No, what is the original authorization#:			
Indicate here if OK to withdraw the request if no authorization is required: Yes No (process request as pre-d)			
Section D: Ordering Provider Information			
Physician Name:		NPI:	
Phone:		Fax:	
Section E: Servicing Provider Information			
Physician/Facility Name:		NPI:	
Phone:		Fax:	

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Section F: Additional Durable Medical Equipment Details Retail Purchase Price Quantity Purchase **HCPC Code** Rental Repair Replacement \$ \$ \$ \$ **Section G: Additional Home Health Details** SW RN ST HHA Quantity CPT Code(s) Indicate here if OK to amend to MCG recommended number of visits for home health requests: □ No **Section H: Additional Comments**

Prior Authorizations requests are required by the health plan, per the SPD, EOC and/or COC. Failure to obtained Prior Authorization will result in a penalty. See your specific health plan for a list of required services and penalties.

Pre-determination requests are not required by the health plan, per the SPD, EOC and/or COC. These are medical done as a courtesy to the provider or member. See your specific health plan for specific coverage questions.

Prior authorization and pre-determination requests are medical necessity reviews only, unless otherwise indicated on the decision letter. It is the member and providers responsibility to check in-network and out-of-network providers and benefits.

Please note decision timelines are as follows:

Urgent: within 72 hours of request receipt

Non-Urgent: within 14 calendar days of request receipt

Concurrent: within 72 hours of request receipt

Post-Service: within 14 calendar days of request receipt

Experimental & Investigational: within 5 calendar days of request receipt

Urgent Part B: within 24 hours of request receipt Non-Urgent Part B: within 72 hours of request receipt

Network Health Utilization Management Department

Phone: 920-720-1602, Toll-free 866-709-0019 | Fax: 920-720-1916

Secure Email: pophealthutiliza@networkhealth.com
Business Hours: Monday-Friday, 8:00 a.m. to 5:00 p.m.