

Please complete each section of this form. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: _____ Date of Birth: _____

Member ID Number: _____ Group Number: _____

ICD code(s), please list all that apply: _____

CPT & HCPCS code(s), please list all that apply: _____

Place of Service _____

NPI/Tax ID Number: _____

Admission/Procedure/Service Date: _____ Days/Units Requested: _____

Inpatient Services

- | | | |
|---|--|---|
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Gastric/Weight Loss Surgery | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Hospital Notification (first 5 days) | <input type="checkbox"/> Medical or Surgical* | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Swing Bed | <input type="checkbox"/> Transplant, type _____ |
| <input type="checkbox"/> Other: _____ | | |

* Maternity and newborn cases do not require preauthorization for inpatient stays less than 48 hours for vaginal delivery or less than 96 hours for cesarean section. Facilities must request extensions for hospital stays if the stay extends beyond the approved number of days.

Outpatient Services

- | | | |
|---|---|--|
| <input type="checkbox"/> Ambulance/Transportation | <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Applied Behavioral Analysis Therapy |
| <input type="checkbox"/> Breast Reconstruction/Reduction | <input type="checkbox"/> Chiropractic Services* | <input type="checkbox"/> Clinical Trial |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Endovenous Ablation Therapy |
| <input type="checkbox"/> Gastric/Weight Loss Surgery | <input type="checkbox"/> Genetic/Pharmacogenetic Testing | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Home Health Care Services | <input type="checkbox"/> Hospice | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> In-Network Benefits for an Out-of-Network Provider | <input type="checkbox"/> Infertility Diagnostic Services | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Occupational Therapy* | <input type="checkbox"/> Orthotics & Prosthetics | <input type="checkbox"/> Pain Management Services |
| <input type="checkbox"/> Physical Therapy* | <input type="checkbox"/> Plastic/Reconstructive Surgery | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Residential Treatment | <input type="checkbox"/> Speech Therapy* |
| <input type="checkbox"/> Spinal Disc Replacement | <input type="checkbox"/> Spine Fusion | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> TMS Therapy | <input type="checkbox"/> Transplant Services, type: _____ | <input type="checkbox"/> Other: _____ |

* Only required if over their limited number of visits. Please specify the number of additional visits being requested: _____

Durable Medical Equipment

- | | | |
|--|---|---|
| <input type="checkbox"/> Bone/Joint Stimulator | <input type="checkbox"/> Chest Vest | <input type="checkbox"/> Continuous Glucose Monitor |
| <input type="checkbox"/> Hemodialysis Machine & Supplies | <input type="checkbox"/> Hyperbaric Oxygen | <input type="checkbox"/> Infusion/Implantable Pump |
| <input type="checkbox"/> Lift Systems | <input type="checkbox"/> Medical Bed/Mattress | <input type="checkbox"/> Nerve Stimulation Systems |
| <input type="checkbox"/> Neuromuscular Stimulation Systems | <input type="checkbox"/> Nutrition, Enteral | <input type="checkbox"/> Nutrition, Parenteral |
| <input type="checkbox"/> Oxygen & Supplies | <input type="checkbox"/> Passive Motion Exercise Device | <input type="checkbox"/> Pneumatic Compression Device |
| <input type="checkbox"/> Speech Generating Devices & Accessories | <input type="checkbox"/> Transfer Systems | <input type="checkbox"/> Ultraviolet Therapy |
| <input type="checkbox"/> Wheelchair/Mobility Devices & Accessories | <input type="checkbox"/> Wound Therapy Devices & Supplies | <input type="checkbox"/> Other: _____ |

Provider Name: _____ Today's Date: _____

Person completing the form: _____ Office/Facility Name: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

(See Next Page)

Determination of medical necessity requires the submission of documentation.

Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records: _____

Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Final determination will be faxed to the prescriber. Final determination will be mailed to the member.

IMPORTANT NOTICE: This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim. If you have questions about your benefits, please contact Avera Health Plans Service Center at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send a secure email to HealthServices@AveraHealthPlans.com.