AmidaCare Fax Form for Case Submission

<u>*All fields must be completed for case submission*</u>

1. Member First Name:	**2. Member Last Name:**	
3. Date of Birth:	**4. Member ID Number:**	
5. Admission/ Service Start Date:	**6. All ICD 9 Codes:**	**7. All CPT Codes:**
8. Requesting Provider Name:	**9. Requesting Provider NPI:**	**10. Requesting Provider Address:**
11. Servicing Provider Name:	**12. Servicing Provider NPI:**	**13. Servicing Provider Address:**

14. Treatment Setting (Please check one)**:**

☐ **Acupuncture** ☐ **ADHC** ☐ **Amniocentesis** ☐ **Birthing Center** ☐ **Blood Donation** ☐ **Cardiac Rehab** ☐ **Chemotherapy** ☐ **Court Ordered Services** ☐ **Dialysis** ☐ **DME** ☐ **ER** ☐ **GRS (Gender Re-Assignment Surgery)**	☐ **HHC** ☐ **Hospice IP** ☐ **Hospice OP** ☐ **Imaging Studies** ☐ **Inpatient Admission** ☐ **Inpatient Rehab** ☐ **LTAC** ☐ **Office Visit** ☐ **Outpatient Rehab** ☐ **Outpatient Surgery**	☐ **Pain Management** ☐ **Palliative Care** ☐ **PCA** ☐ **PERS** ☐ **Plastic Surgery** ☐ **Private Duty Nursing** ☐ **Sleep Study** ☐ **SNF** ☐ **Transplant** ☐ **Transportation**

15. Number of Days/Units Requested:	**16. Contact Name:**
17. Contact Phone Number:	**18. Contact Fax Number:**

Please attach all clinical information with your request

19. Amida Care Response:

☐ **NO PRIOR AUTHORIZATION REQUIRED**

☐ **AUTHORIZATION IS ALREADY ON FILE AND PENDING UM REVIEW**

☐ **DUPLICATE REQUEST (AUTHORIZATION IS ALREADY ON FILE & APPROVED): _____**

☐ **OTHER: _____**

<u>HSNP Requests Fax To: 855-663-6480</u>