



Amida Care Fax Form for Case Submission

All fields must be completed for case submission

1. Member First Name:		2. Member Last Name:				
3. Date of Birth:	4. Procedures	5. Member ID Number:				
6. Admission/Service Start Date:		7. All ICD 10 Codes:	8. All CPT Codes:			
9. Requesting Provider Name:		10. Requesting Provider NPI:	11. Requesting Provider Address:			
12. Servicing Provider Name:		13. Agency TIN:	14. Servicing Provider Address:			
15. Treatment Setting (Please check one):						
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Acupuncture <input type="checkbox"/> ADHC <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Birthing Center <input type="checkbox"/> Blood Donation <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Court Ordered Services <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> ER </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> GAS (Gender Affirming Surgery) Home Care <input type="checkbox"/> HHC <input type="checkbox"/> Hospice IP <input type="checkbox"/> Hospice OP <input type="checkbox"/> Imaging Studies <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> LTAC <input type="checkbox"/> Office Visit <input type="checkbox"/> Outpatient Rehab </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care <input type="checkbox"/> PCA <input type="checkbox"/> PERS <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Private Duty Nursing <input type="checkbox"/> Sleep Study <input type="checkbox"/> SNF <input type="checkbox"/> Transplant <input type="checkbox"/> Transportation </td> </tr> </table> <p><input type="checkbox"/> GAS (Gender Affirming Surgery) Documents Included: ___ Inpatient ___ Outpatient ___ Clinical Documentation ___ Letter #1 ___ Letter #2</p>				<input type="checkbox"/> Acupuncture <input type="checkbox"/> ADHC <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Birthing Center <input type="checkbox"/> Blood Donation <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Court Ordered Services <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> ER	<input type="checkbox"/> GAS (Gender Affirming Surgery) Home Care <input type="checkbox"/> HHC <input type="checkbox"/> Hospice IP <input type="checkbox"/> Hospice OP <input type="checkbox"/> Imaging Studies <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> LTAC <input type="checkbox"/> Office Visit <input type="checkbox"/> Outpatient Rehab	<input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care <input type="checkbox"/> PCA <input type="checkbox"/> PERS <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Private Duty Nursing <input type="checkbox"/> Sleep Study <input type="checkbox"/> SNF <input type="checkbox"/> Transplant <input type="checkbox"/> Transportation
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16. Number of Days/Units Requested:		17. Contact Name:				
18. Contact Phone Number:		19. Contact Fax Number:				
Please attach all clinical information with your request						
20. Amida Care Response:						
<input type="checkbox"/> NO PRIOR AUTHORIZATION REQUIRED <input type="checkbox"/> AUTHORIZATION IS ALREADY ON FILE AND PENDING UM REVIEW <input type="checkbox"/> DUPLICATE REQUEST (AUTHORIZATION IS ALREADY ON FILE & APPROVED): _____ <input type="checkbox"/> OTHER: _____						
<u>HSNP Requests Fax To: 888-273-8296</u>						