SOLIS HEALTH PLANS

Request for Service Authorization Form

To submit a request, please fax a completed form to: **833-210-8141**

To speak to a representative, contact the Utilization Management Department at: **833-615-9260**

NOTE: Providers must obtain prior authorization prior to scheduling a service. Please submit clinical information as needed to support the medical necessity for the request. Please make sure this form is completed accurately and completely in order not to delay any service request. ICD-10 and CPT codes should be included. As a reminder, an authorization/certification number is not a guarantee of payment. Payment is subject to verification of benefit and coverage. We encourage the use of the Solis Provider Portal as this will facilitate timely response.

PLEASE FAX YOUR ALL REQUESTS FOR HOME HEALTH, DME OR INFUSION SERVICES TO IHCS:
FAX 844-215-4265, PH: 844-215-4264.

Request Type:	
☐ Standard Request	Solis has **14 days** from requested date to provide an organizational determination if all sufficient clinical information is received with the request and can be extended an additional 14 days for any additional information needed.
☐ Expedited Request*	Solis has **72 hours** for all expedited requests to render a decision and can extend timeframe for an additional 14 days. *By checking this box Provider must sign the below attestation certifying that applying the standard time frame would seriously jeopardize the life or health of the member.
Date Signed: ___/___/_____	***Physician Signature:**

For Part B Injectable Requests:	
☐ Standard Request	Solis has **72 hours** from requested date to provide an organizational determination if all sufficient clinical information is received with the request and can be extended an additional 14 days for any additional information needed.
☐ Expedited Request*	Solis has **24 hours** from requested date to provide an organizational determination if all sufficient clinical information is received with the request and can be extended an additional 14 days for any additional information needed. *By checking this box Provider must sign below attestation certifying that applying the standard time frame would seriously jeopardize the life or health of the member.
Are you a **contracted BUY AND BILL** Provider?	☐ Yes ☐ No
Date Signed: ___/___/_____	***Physician Signature:**

1. MEMBER INFORMATION:

Member First Name:	
Member Last Name:	
Solis Member ID Number:	Medicare Number:
Date of Birth: ____/____/_____	Gender: ☐ Female ☐ Male

2. PROVIDER INFORMATION:

Referring (Submitting) Provider:	Referring Provider NPI **AND** TAX ID number:	Contact Name: _____ Phone: _____ Fax: _____
Servicing (Treating) Provider:	Servicing Provider NPI **AND** TAX ID number:	Facility NPI **AND** TAX ID number:
Admitting Provider:	Admitting Provider NPI **AND** TAX ID number:	Group Name:

3. TYPE OF REQUEST: (TREATMENT SETTING)

☐ Office
☐ Outpatient
☐ Inpatient
☐ Mental Health
☐ Home
☐ Other: _____

4. ICD-10/ CPT CODE/HCPCS**:							
ICD-10	**CPT Code/ HCPCS**	**Date of Service: From/To**	**Dose**	**Frequency**	**# of Treatments**	**Units**	**Visits**

**** For all requests please attach medication orders.**

Solis Health Plans may limit authorization timeframes to three (3) months.

5. THERAPY OR REHABILITATION SERVICES:		
Date: ____/____/_____		Number of Units or Visits Requested: _____
Type of Therapy: ☐ PT ☐ ST ☐ OT ☐ Other: _____		
Prior Authorization Number or Certification: _____		
Initial:	Extension:	Date(s) Requested:

Notes: