SOLIS HEALTH PLANS

2026 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 or 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 all requests for home health, DME, or infusion services to IHCS to: **844-215-4265**.
To speak to a representative, contact them at: **844-215-4264**.

Request Type	
Standard Request ☐	Solis has **7 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 7 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, the 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 All HCPCS Level II requests for medications covered under Medicare Part B must include a valid treatment plan at the time of submission.	
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 7 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:**

Member Information	
Member First Name:	**Member Last Name:**
Date of Birth:	**Gender:** ☐ Female ☐ Male
Solis Member ID Number:	**Medicare Number:**

Provider Information		
Referring (Submitting) Provider:	Referring Provider NPI **AND** Tax ID Number:	Contact Information (Required): 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:

Type of Request (Treatment Setting)

- ☐ **Office**
- ☐ **Outpatient**
- ☐ **Inpatient Levels of Care (LOC)**
  - ☐ Observation
  - ☐ Behavioral Health - Psychiatric Admission
    - ☐ Elective (Voluntary)
    - ☐ Baker Acted (Involuntary)
  - ☐ Inpatient - Medical
- ☐ **Post Acute Level of Care (LOC)**
  - ☐ Skilled Nursing Facility (SNF)
  - ☐ Inpatient Rehab Facility (IRF)
  - ☐ Long Term Acute Care (LTAC)
- ☐ **Mental Health**
- ☐ **Home**
- ☐ **Other:**

Certified Treatment Period	
Treatment Start:	**Treatment End:**

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 time frames to three (3) months.

Therapy or Rehabilitation Services		
Date:		**Number of Units/Visits Requested:**
Type of Therapy: ☐ PT ☐ ST ☐ OT ☐ Other		
Prior Authorization Number or Certification:		
Initial:	**Extension:**	**Date(s) Requested:**
Notes:		