AmeriHealth Caritas
District of Columbia

Request for Authorization

Providers are responsible for obtaining prior authorization for services prior to scheduling. Please submit clinical information, as needed, to support medical necessity of the request. Requests will not be processed if missing clinical information or CPT and ICD-10 codes. As a reminder, authorization is not a guarantee of payment; payment is subject to benefit coverage rules, including member eligibility and any contractual limitations in effect at the time of service.

To submit requests, please fax completed form to:
202-408-1031 or **1-877-759-6216**

For assistance, please contact Utilization Management (UM) at:
202-408-4823 or **1-800-408-7510**

Today's date: _____ Requested date of service: _____

☐	Standard request	AmeriHealth Caritas District of Columbia (DC) has up to 14 days to render a decision for standard requests.
☐	Priority request	Services are scheduled for the following date:
☐	Urgent	I certify that applying the standard review time frame may seriously jeopardize the life or health of the member.

Physician's signature: _____ Date signed: _____

A. Member information

Alliance/Medicaid ID number:	Enrollee last name:	Enrollee first name:
Date of birth: / /	Gender: ☐ Male ☐ Female	

B. Review type

☐ Initial	☐ *Change DOS/setting	☐ *Extension of services	☐ Additional clinical
☐ Cancel	☐ *Other (specify)	☐ Discharge planning (services needed for member discharged from inpatient setting such as hospital, skilled nursing facility, etc.)	

*Please specify (If applicable, previous authorization number): _____

Service type:

☐ Orthotics/prosthetic	☐ Home care	☐ Non-par	☐ Durable medical equipment (DME)
☐ *Other	☐ OB/GYN (obstetrics/gynecology)	☐ CWSN (Children with special needs 3 – 21 years of age. If under 3 years of age, call **1-877-759-6224** for further assistance.)	

*Please specify (if applicable, previous authorization number): _____

C. Provider information

Submitting provider name:	Contact name and phone number:	Fax number:
Services provided by or facility/provider ID number:	Contact name and phone number:	Fax number:

Do not write below this line: fields to be completed by AmeriHealth Caritas DC.

Authorization number: _____ AmeriHealth Caritas DC UM assistant name: _____

AmeriHealth Caritas District of Columbia
1120 Vermont Ave. NW, Suite 200
Washington, DC 20005

Contact Utilization Management (UM)
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Treatment setting: Member ID number: _____

☐ Outpatient	☐ Inpatient	☐ Home	☐ In-office	☐ *Other

*Please specify if other selected: _____

D. ICD-10, HCPCS/CPT codes

ICD-10 code	HCPCS/CPT	Code description	Dates of service	
			From	Through
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

Other clinical information — Include or attach clinical or office notes, labs, imaging reports, etc., to support medical necessity. If this is an out-of-network request, please provide an explanation.

E. Rehabilitation services

Type of therapy:	☐ Speech	☐ Physical	☐ Occupational	☐ Other
Number of units/visits requested:		Previous authorization number:		Date(s) requested :
☐ Extension		☐ Initial		
Additional comments:				

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Member ID number: _____

F. Home care		
Name of agency:	Number of units/visits requested:	Number of previous visits:
Previous authorization number:	☐ Initial	☐ Extension
Additional comments:		

G. Durable medical equipment (DME)		
Diagnostic indication:	Duration and frequency of use:	Acute or chronic condition:
Previous authorization number:	Length of time needed:	
☐ Initial	☐ Renewal	
☐ Rental	☐ Purchase	
Additional comments:		

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AmeriHealth Caritas District of Columbia

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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