Amalgamated Medical Care Management
Quality Clinical Advice & Care

Utilization Review Authorization Form

Please complete **ALL** applicable fields in this form and submit all additional treatment information and/or medical notes that support your request for services. Failure to submit the Utilization Review Auth Form and clinical will prevent AMCM from processing your request in a timely manner.

*Denotes a Required Field

*Contact/Person Submitting Request:		*Today's Date:
*Telephone #:	*Fax #:	Email:

*Check **ONLY** one: Initial Request ❑ MCR Request ❑ Retro Request ❑ Appeal Request ❑

*Check if Expedited Review/Urgent Request ❑
(In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

Patient/Member Information

*First Name:	Middle Initial:	*Last Name:	
*DOB:	Member/Subscriber ID:	Gender: Male ❑ Female ❑ Unknown ❑	
*Address:			
*City	*State:	*Zip:	

Servicing/Treating Provider Information			Facility		
*First Name:	*Last Name:		*First Name:	*Last Name:	
*NPI/TIN #:			*NPI:		
*Group/Practice/Agency Name:			*Group/Practice Name:		
*NPI:			*NPI/TIN #:		
*Address:		Suite #:	*Address:		Suite #:
*City:	*State:	*Zip:	*City:	*State:	*Zip:
*Telephone #:	*Fax #:		*Telephone #:	*Fax #:	

Required Clinical Information

*Is this request for Out-of-Network Services?	Yes ❑	No ❑
*Primary Diagnosis (ICD-10 Code):		*Secondary Diagnosis (ICD-10 Code):

*Service Type Requiring Authorization

Not all services listed will be covered by the benefits in a member's health plan product.

Ambulatory/Outpatient Services (OP) ❑ Surgery/Procedure ❑ Infusion/Oncology Drugs ❑ Radiation Therapy ❑ Infertility ❑ Diagnostic Imaging	Outpatient Therapy ❑ Occupational Therapy (OT) ❑ Physical Therapy (PT) ❑ Pulmonary/Cardiac Rehab ❑ Speech Therapy (ST) ❑ Acupuncture ❑ Chiropractic	Inpatient Care (INPT) ❑ Acute/Intermediate/Critical ❑ Long Term Acute Rehab (LTAC) ❑ Acute Rehab ❑ Skilled Nursing Facility (SNF) ❑ Infusion/Oncology Drugs ❑ Listed Transplants ❑ OB/NICU	Durable Medical Equipment ❑ Prosthetic Device ❑ Diabetic Supplies ❑ External Hearing Aids ❑ Cochlear Implants ❑ Purchase ❑ Rental
Nutrition/Counseling ❑ Counseling ❑ Enteral Nutrition ❑ Infant Formula ❑ Total Parental Nutrition (TPN/IL) ❑ Nutritional Supplements	Home Health ❑ Infusion Therapy ❑ Skilled Nursing ❑ Wound Care ❑ PT ❑ OT ❑ ST	Mental Health/Behaviroal Therapy ❑ Inpatient Psych ❑ Full Day ❑ Half Day ❑ Outpatient ❑ PHP ❑ IOP ❑ INPT Substance Abuse ❑ OP Substance Abuse ❑ ABA Therapy	Medical Claim Review (MCR) ❑ Non-emergent Ground ❑ Non-emergent Air ❑ ED Visits ❑ Laboratory ❑ Anesthesia
Hospice *Certificate of Life Expectancy must be sent with request. *Day 30+ will require LOMN ❑ Inpatient ❑ Outpatient		Other—Please Specify (Additional information, appeal, reconsideration, cert/auth #, etc.):	

Please proceed to page 2 to complete the required section that is associated with and supports your service type request.

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Utilization Review Authorization Form (Page 2)

Patient/Member Information

*Planned Service/Procedure(s) (CPT/HCPC Code):		
*Proposed Date(s) of Service: From:	To:	*Total # of Days:
*Other—please specify:		

*DME Requests:

For CPAP/BiPAP: Initial request requires face-to-face evaluation & polysomnogram. Ongoing treatment requires compliance report & face-to-face evaluation.

*Requested DME:		*Requested DME Duration (Date(s) of Service):	
*DME CPT/HCPCS Code:		*DME Purchase Price: $	*DME Monthly Rental Price: $

*Therapy Request:

All PT requests require an Eval. Additional visits require signed physician script/order.

*Referring Provider First Name:		*Referring Provider Last Name:	
*Referring Provider NPI:		Specialty:	
*Group/Practice Name:		*Group NPI:	
*Address:			Suite #:
*City:		*State:	*Zip:
*Telephone:		*Fax:	

*CPT/HCPC Code	*Start Date	*End Date:	*# of Visits/Units

Misc/Additional Information:

- Please attach additional pages if needed. IE: Radiation/Chemo codes, additional CPT/HCPC codes for therapies, etc.
- Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.
- The form is currently not intended to capture supporting clinical documentation.
  - Including plans specific templates
- Some services may require physician signature and should be submitted with the supporting clinical documentation.