Vaya Partners

Physical Health Outpatient Service Authorization Request Form

Use this form to request prior authorization of outpatient medical (physical health) services/procedures if you are unable to access Vaya Partners provider portal, ProviderCONNECT. When possible, Vaya Partners strongly prefers service authorization requests (SARs) be submitted through the portal.

Submission Requirements

- Fax completed forms to 828-262-1859.
- Do not combine forms and records for multiple patients in one fax. Per Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, send separate faxes for each patient.

DO NOT USE THIS FORM FOR:	INSTEAD:
Inpatient admissions (acute/emergent admissions) or **concurrent reviews**	Use the Physical Health Inpatient Admission Notification and SAR Form on our Prior Authorization webpage
Post-acute facility admissions (e.g., skilled nursing facility [SNF], Subacute Rehabilitation, or long-term acute care hospital [LTACH])	Use the Post-Acute Facility SAR Form on our Prior Authorization webpage
Behavioral health, intellectual/developmental disability (I/DD), and traumatic brain injury (TBI) authorization requests	Use the Behavioral Health SAR Form on our Prior Authorization webpage
Personal Care Services (PCS) requests	Use the Request for Independent Assessment for Personal Care Services Referral Form on our Prior Authorization webpage and fax to 828-262-1859
Radiology, cardiology, durable medical equipment (DME), and outpatient specialized therapy requests (e.g., physical therapy, occupational therapy)	Contact EviCore healthcare at 1-800-918-8924, ext. 24176, or evicore.com/provider
Non-Emergency Medical Transportation (NEMT) requests	Contact Modivcare Solutions, LLC, at 1-855-397-3606 or modivcare.com
Comprehensive eye and vision services, including medical/surgical procedures	Contact Avēsis, LLC, at myavesis.com/contact-us

All requests must be accompanied by supporting medical records, including physicians' orders, notes, test results, etc. Failure to provide complete information and required medical records will result in authorization delays. For more information, visit the Authorization Guidelines page of Vaya Partners' ProviderCENTRAL website.

Member Information

Last name: _____ First name: _____

Medicaid ID #: _____ Date of birth: _____

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Requesting Provider/Facility Information

Provider name: _____ ☐ Network provider ☐ Out-of-Network provider

Provider TIN: _____ Provider NPI: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Name of person making request: _____ Phone: _____

Email: _____ Fax: _____

Servicing Provider/Facility Information

Complete this section only if the servicing provider/facility is not the same as the requesting provider/facility.

Facility name: _____ ☐ Network provider ☐ Out-of-Network provider

Facility TIN: _____ Facility NPI: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Email: _____

Request Information

Place of Service ☐ Home ☐ Office ☐ Outpatient hospital

☐ Other (describe): _____

Diagnosis

ICD-10 diagnosis code: _____ Description: _____

Second ICD-10 diagnosis code: _____ Description: _____

If you are requesting an elective/planned outpatient procedure, explain the rationale for the outpatient site of service.

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Type of Service	Service Code (CPT/HCPCS)	Start Date	Unit Type	# of Units Requested

Additional information (optional):

Expedited Requests

☐ Check this box to request an expedited review if the standard timeframe for making a determination could seriously jeopardize the life or health of the patient or seriously jeopardize the patient's ability to attain, maintain, or regain maximum function. **You must submit medical documentation that clearly supports the need for an expedited review.**

By submitting this form, the requesting provider certifies that the information given is true, accurate, and complete.

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