CARE IMPROVEMENT PLUS
Specialized care for Medicare beneficiaries

Preauthorization Line 1-888-625-2204
Hours of Operation: 8:30 am – 5:00 pm

Submission Date: ____/ _____/____ **Provider Request Form**

Care Improvement Plus Member Information

Last Name: _____ **First Name:** _____ **Middle Initial** ____

SUBSCRIBER ID# _____ **Date of Birth** _____

Medicaid # (if applicable): _____ **Other Insurance Name/Policy #:** _____

If Inpatient, admitting from: ER Home SNF LTACH IRF Hospice Acute Hospital LTC or ALF

Service Provider *Service Start Date:* ____/____/____ *Service End Date:* ____/____/____

Provider/Vendor Name: _____ **Tax ID#:** _____

Contact Name: _____ **Phone Number:** _____ **ext.**_____ **Fax#**_____

Provider/Vendor Address: _____

Ordering Physician: _____ **Phone Number:** _____ **Fax#**_____

ICD9 Codes/Description: _____ **CPT/HCPCS Codes** _____; _____

Service Type – *please check the type of service you are requesting and submit the supporting documentation* with this form. *See Fax numbers for each service below.

☐ **Inpatient Hospital Admission Notification**
Please notify us all hospital admissions within 1 business day and include a physician order.

☐ **Elective Hospital Services**
Please submit requests at least 14 calendar days prior to the scheduled procedure for the services below:
* Blepharoplasty
* Bariatric Procedures (weight loss)
* LVAD
*Elective Permanent Pacers
*ICD's
* Organ and Bone Marrow
*Transplants (see number below)

☐ **Long Term Acute Hospital (LTACH)**

☐ **Skilled Nursing (SNF)**

☐ **Inpatient Rehab (IRF)**
Please fax the physician's order, physical, occupational and speech therapy evaluations and/or skilled nursing orders for treatments such as IV antibiotic orders, wound care orders, etc.

☐ **Durable Medical Equipment Request**

Please refer to your **Provider Fact Sheet** for the specific information that is needed for the selected DME below:
* Power Wheelchairs
* Power Operated Vehicles
* Wound Vac
* Lymphedema Pump
* Lower Limb Prosthesis
* Bone Growth Stimulators
* Spinal Cord Stimulator (Pain Management)
* Air Fluidized Beds (in home)

☐ **Home Health**

Once the care has been initiated, within the first week, please submit the MD order or 485 POC.
*Please fax the notes from the initial visit.
*When requesting on-going episodes of care, please fax the notes from the last visit and goals for the additional episodes of care.

Please fax completed form for the below services to:

HOME HEALTH 1-866-219-2923
INPATIENT HOSP ADMISSION NOTIFICATION 1-800-211-6490
EXPEDITED FAX LINE: 1-888-579-9899
SNF, LTACH, IRF 1-866-304-2382
DME, ELECTIVE HOSPITAL SERVICES, 1-866-224-1151
TRANSPLANTS: 888-936-7246 option 1 / Fax (855) 352-7692

Expedited Fax line: Please use this fax line *only* if the physician ordering the service indicates that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Expedited requests determinations are rendered in 72 hours. CIP determinations for LTACH, SNF and IRF requests are processed within 2 business days of submission of complete information.

NOTE - Authorization is based on a determination that services are medically necessary but is not a guarantee of payment. Payment for services is subject to member eligibility and benefits limitations. NOTE – confirmation of Inpatient Hospital Admission Notification is NOT an authorization of services.