Suburban Health Organization
PO Box 50830
Indianapolis, IN 46250

Advantage Health Solutions Prior Authorization Form

Suburban Health Organization Networks | St. Vincent's CMO

Ph: (317) 570-9999 or (866) 482-5254 Fax: 317-570-6818 or (800) 747-3693

(Includes all authorizations and precertification related calls)

Patient Name: _____ DOB: _____ / _____ / _____

ID#: _____ Insurance Plan: _____

PCP Name: _____ PCP Phone #: (_____) _____ - _____ PCP Fax #: (_____) _____ - _____

Diagnosis: _____ ICD-9 Code(s): _____

Procedure: _____ CPT-4 Code(s): _____

Outpatient ○ Inpatient ○ Observation ○ Requested Service: _____

Vendor/Facility: _____

Date of Requested Service: _____ / _____ / _____ Days/Visits Requested: _____

Referred by: _____ Phone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Person Submitting Request: _____ Phone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Specialty Referral

Specialist Name (MD Name): _____ Specialty: _____

Requested Service: _____ Service Type/Vendor: _____

Date(s) of Service/Procedure: _____ / _____ / _____

Service Type: ○ Consult Only

○ Consult and Treat Additional Medical Information: _____

○ OON _____

○ Documentation Attached _____

Referral Type: ○ Self-Referred Resubmission Date: _____ / _____ / _____

○ Referred by PCP Date Request Received: _____ / _____ / _____

○ OON

If requesting approval for non-participating provider, indicate why participating provider cannot provide service. If request is not completed in full, request will be returned: _____

_____

PLEASE DO NOT WRITE BELOW THIS LINE – FOR ADMINISTRATIVE USE ONLY

Authorization #: _____ # of Visit/Days/Months Approved: _____

Time Frame: _____ / _____ / _____ to _____ / _____ / _____

○ Urgent/Non-Urgent Authorizing Agent: _____

○ Pre-Service/Post-Service Phone #: (_____) _____ - _____

○ Concurrent/Retrospective Date Submitted: _____ / _____ / _____

Revised May-15