

Long Term Services and Support (LTSS)
Authorization Request
Phone: 1-877-301-4394
Fax: 1-866-644-5456

Date Request Submitted: _____		
Member Name: _____		
Address: _____		City: _____
State: _____	ZIP Code: _____	Phone: _____
Person completing Form: _____		Fax: _____
Service Type: <input type="checkbox"/> Agency <input type="checkbox"/> CDS <input type="checkbox"/> SRO		
	New Request?	Current Service?
<input type="checkbox"/> Personal Care Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PAS/Habilitation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Day Activity and Health Services (DAHS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PPECC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Respite	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Employment Assistance	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Flexible Family Support Service	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ERS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adaptive Aids	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Minor Home Mods	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Transition Assistance Service	<input type="checkbox"/>	<input type="checkbox"/>
		Hours/Week: _____
		Hours/Week: _____
		Hours/Week: _____
		Hours/Week: _____
		Hours/Week: _____
		Hours/Week: _____
		Hours/Week: _____
		Hours/Week: _____
		Months: _____
		\$ _____
		\$ _____
		\$ _____
Date of Service: Begin Date: _____ End Date: _____		
Provider NPI/API: _____ Agency Name: _____		
Justification for Request (Diagnosis Code Required): _____		

Certain request for services require specific clinical information for us to authorize requested services. Always include this information with the Request for LTSS Authorization Form. If there's no form available for the service you are requesting authorization for, please submit information from your own files that would support the request. Thank you.

Health Plan Use Only		
Status		
Approved: _____	Expires: _____	Authorization Number: _____
Comments: _____		
Representative Name _____		Nurse Reviewer: _____
This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.		