VillageCareMAX

PRIOR AUTHORIZATION REQUEST FORM

FAX FORM TO 212-402-4468 FOR INPATIENT REVIEWS OR DISCHARGES.
FOR ALL OTHER REQUESTS FAX FORM TO 718-517-2709.

This standard form should be utilized to submit prior authorization request to VCMAX along with the necessary clinical documentation to support the request. Incomplete submissions will be returned unprocessed. If you have any questions, please call 800-469-6292.

☐Expedited Request: Please check if you believe a delay of service could seriously jeopardize the life or health of the member or ability to regain maximum function in serious jeopardy.

MEMBER INFORMATION	
Last Name	First Name
Member ID	DOB

PROVIDER INFORMATION		
Check One: You are the ☐Prescribing/Ordering ☐Referring		
Name	TAX ID	NPI #
Provider Address		
Phone	Fax	Email
Contact Person	Phone	Fax
Check One: You are the ☐Requesting Provider ☐Servicing Provider		
Name	TAX ID	NPI #
Provider Address		
Phone	Fax	Email
Contact Person	Phone	Fax

CLINICAL INFORMATION
Member Symptoms and Duration
Summary of Clinical Findings
Order Description
Medical Justification
Diagnosis

SERVICE TYPE REQUIRING AUTHORIZATION		
Place of Service		
Start Date of Service	End Date of Service	
Order Date	Quantity Requested	Time Requested
Ambulatory/Outpatient Services	**Inpatient Care**	**Outpatient Services**
☐Surgery/Procedure ☐Infusion or Oncology Medications	☐Acute Inpatient Admission ☐Short Term/Acute Rehab ☐Skilled Nursing Facility	☐Physical Therapy ☐Occupational Therapy ☐Speech Therapy
Home Health Services	**Ancillary Services**	**Durable Medical Equipment**
☐Home Health Please circle: SN,PT,ST,MSW ☐Hospice ☐Infusion Therapy ☐Respite Care	☐Acupuncture	☐Prosthetic Device ☐Enteral Supplies ☐Incontinence Supplies ☐Medical Supplies ☐Purchase ☐Rental

Please attach clinical documentation to support the request. I.e. clinical notes, lab results, x-rays etc. Durable Medical Equipment requires a physician signed prescription and letter of medical necessity.