TRILOGY AUTHORIZATION/REFERRAL FORM

□ **STANDARD** □ **** EXPEDITED/URGENT**

****Determination to be made within one calendar day. Faxes received after 4 pm will be reviewed next business day by 12 pm.**

Date: _____ **Patient Name**: _____ **DOB**: _____

Referred By (PCP): _____ **Phone:** _____ **Fax:** _____

Referred To (SPEC): _____ **SPEC Office Address**: _____

Facility: _____

Requested Dates: **From:** _____ **To:** _____ **Units/Visits:**_____

Diagnosis (ICD-10): _____ _____ _____

Procedure (CPT/HCPCS/Units): _____ _____ _____

Type of Authorization:

- □ Observation (Non Par Only)
- □ Case Management
- □ Inpatient Rehabilitation
- □ Maternity
- □ Outpatient Surgery
- □ Inpatient
- □ Pre-Authorization
- □ Referral
- □ Non-Emergency Transport
- □ Second Opinion
- □ Skilled Nursing Facility
- □ LTAC
- □ Sub Acute Admission
- □ Transplant
- □ DME Repair
- □ Home Health Care
- □ Therapy (PT/OT/ST)
- □ DME Purchase
- □ DME Rental

The following authorizations require the additional documentation listed to be faxed along with this form:

- Diagnostic Procedures - Physician Order & Clinical Documentation
- Durable Medical Equipment (Purchase or Rental) -Physicians Order & State Prior Auth./Oxygen Attachment
- Durable Medical Equipment (Repair) - Physicians Order and Work Order
- Home Health – 485 Form
- Hospice – State Physician Certification & Recertification of Terminal Illness
- PCW – PA/RF & HCAF & 485 & PCW Instructions
- Rehabilitation – Physician Order & Initial Evaluation
- RN Supervisory – PA/RF & HCAF & 485 & PCW Instructions
- Therapy (PT/OT/SP) requires Physician Order & Initial Evaluation

FAX Form and other pertinent documents to IPN at (414) 771-1159

Please Note:

- **All authorizations for in-network and out-of-network services must be faxed to IPN and approved before services are provided.**
- **Authorization for Medically Necessary Services is NOT a guarantee of eligibility or payment.**

*******For Trilogy Use Only*******

Authorization Approved: _____Yes _____No Date Approved/Denied: _____Initials:_____

Approved Authorization Confirmation #_____Authorization Expiration Date:_____

Reason for Denial: _____

Fax Number Confirmation Sent To:_____ Date:_____Initials: _____

(No authorization may exceed 180 days from date authorized without prior approval)

CONFIDENTIALITY NOTE: This form contains privileged and confidential information intended only for the use of the addressee. If you are not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that reading it is strictly prohibited. If you have received this information in error, please immediately return it to the sender and delete it from your system. Thank you.