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 Address:** _____ **SPEC Fax:** _____

Facility: _____ **Facility Tax ID:** _____ **Facility NPI:** _____

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)