

Aplos Health Plans Preauthorization Request Form

Submit completed forms and clinical information outlined below by fax to **515-328-6597**, or by secure email to Aplos@innovativecare.com.

"A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could **seriously jeopardize the life or health of the claimant** or the **ability of the claimant to regain maximum function**; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to **severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.**"

☐ I certify that this request meets the above definition for Urgent processing according to the [Department of Labor](#).

Patient Information

Last Name	First Name	Date of Birth
Employer/Plan Name		Plan ID
Address, City, State, Zip		Phone
Subscriber Name (if different than patient)		Subscriber Relationship

Your Contact Information (Submitted by)

Name	Phone	Fax
Email		

Provider Information

Provider Name	Specialty
Phone	Fax
Provider Primary Address (include suite # if applicable)	NPI
	TIN

Facility Information

Facility	
Phone	Fax
Facility Address (include suite # if applicable)	NPI
	TIN

See next page for service details

Service Request	
Date of Service _____ ☐ Not Scheduled	
☐ Inpatient ☐ Residential ☐ SNF ☐ Outpatient Surgery ☐ Other (LTAC, IPR, Inpatient Hospice): _____ Requested Length of Stay: _____	
Outpatient Services ☐ Imaging ☐ Laboratory Testing ☐ PHP ☐ IOP ☐ Other: _____ Number of Sessions: _____ Duration: _____ Frequency: _____	
Therapies ☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Acupuncture ☐ Chiropractic Treatment ☐ Home Health (specify type: RN, MSW, etc): _____ ☐ Other: _____ Location: ☐ Outpatient/facility-based ☐ Home Number of Sessions: _____ Duration: _____ Frequency: _____ Date of Initial Evaluation for this condition: _____	
DME ☐ Rental Rental Price*: _____ ☐ Purchase Purchase Price*: _____ Duration: _____ *Certain plans only require prior authorization for DME over a certain dollar amount. In order to determine if the request requires prior-authorization, please include rental or purchase price.	
Medications Requested number of infusions/injections: _____ Duration: _____ Frequency: _____ Is this "buy & bill"? ☐ Yes ☐ No	
Description of Service(s) Requested	
CPT Code(s)	ICD Code(s)

Clinical Information: For General Preauthorization requests, please as appropriate:

- ☐ Most recent **History & Physical**
- ☐ Most recent **office visit note(s)** documenting symptoms and conservative therapy as applicable
- ☐ Related **imaging reports**, i.e, X-ray, MRI, CT
- ☐ Related **laboratory reports**
- ☐ Related **Operative Reports**
- ☐ Written **Prescription** for DME, Therapies, etc. as applicable
- ☐ Any other **pertinent clinical information** that substantiates medical necessity for the requested service(s)

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