Summit COMMUNITY CARE

Physical Health and Support Services Precertification Form

To prevent a delay in processing, complete this form in its entirety with all applicable information, then fax to the appropriate services fax number. Staff can be reached by phone if needed. Phone: **844-462-0022**

Physical health services fax: **800-964-3627**
Human development center (HDC) and intermediate care facility (ICF) fax: **844-815-4711**
Long-term care (LTC), long-term services and support (LTSS), community and employment support (CES) waiver, and personal care services fax*: **844-815-4715**

Today's date: _____
Provider return phone: _____
Provider return fax: _____

Member information:		
First name:	Last name:	Member ID:
DOB:	Contact phone:	
Address:		
City:	State:	ZIP:
Other insurance:		

Check one of the two boxes below that appropriately defines the level of urgency. Checking a box that is inappropriate for the service requested may require correspondence from our staff and could delay the completion of your request.

☐ **Standard:** Decision of request will be completed within two business days of receipt of sufficient clinical information.
☐ **Urgent:** Expedited/urgent/STAT request is defined as serious jeopardy to the life, health, or safety of the member. Decision of request will be completed within one business day of receipt of sufficient clinical information, but not later than 72 hours from the date of the initial request. **Retrospective requests are not urgent because the service has already been provided.**

Type of service (check all that apply):	☐ ADDT/EIDT ☐ Diagnostic ☐ DME ☐ HDC ☐ Home health ☐ Hospice ☐ Inpatient ☐ Intermediate care facility ☐ *LTSS/CES waiver** ☐ Observation ☐ Outpatient ☐ Personal care services* ☐ Skilled nursing facility ☐ Other:
Place of service (POS):	☐ Ambulatory surgery center ☐ Home ☐ Hospital ☐ Independent clinic ☐ Independent lab ☐ Intermediate care facility ☐ Office ☐ School ☐ Other (Two-digit code/POS):

Ordering/referring provider: ☐ Participating ☐ Non-participating			
Full name:		Specialty:	
NPI:	TIN:	Arkansas Medicaid Provider ID (PIN):	
Contact name:	Office phone:	Office fax:	
Address:	City:	State:	ZIP:

Servicing provider: ☐ Participating ☐ Non-participating			
If OON, will you accept Summit Community Care rates? ☐ Yes ☐ No		Have you seen this member before? ☐ Yes ☐ No	
Full name:		Specialty:	
NPI:	TIN:	Arkansas Medicaid Provider ID (PIN):	
Contact name:	Office phone:	Office fax:	
Address:	City:	State:	ZIP:

Servicing facility: ☐ Participating ☐ Non-participating			
If OON, will you accept Summit Community Care rates? ☐ Yes ☐ No		Have you seen this member before? ☐ Yes ☐ No	
Name:			
NPI:	TIN:	Arkansas Medicaid Provider ID (PIN):	
Contact name:	Facility phone:	Facility fax:	
Address:	City:	State:	ZIP:

Requested service
Date/date range of service (for multi-day service, include a start and end date):
ICD-10 code(s):
CPT® code(s) and units requested:
Additional information:

Submit all appropriate clinical information, provider contact information, and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Summit Community Care, provide the authorization number with your submission.

*** Disclaimer:** Authorization is based on verification of member eligibility and benefit coverage at the time of service. Authorization is subject to claims payment policies and procedures for Summit Community Care.