Summit COMMUNITY CARE

Physical Health and Support Services Precertification Form

Phone: **844-462-0022**
Please fax all physical health service requests to **800-964-3627**.
* Please fax all *LTC/LTSS/CES Waiver* and personal care services requests to **844-815-4715**.
To prevent a delay in processing, complete this form in its entirety with all applicable information.

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 care/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 no 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	☐ Home health	☐ Hospice
☐ Inpatient	☐ Intermediate care facility	☐ ***LTSS/CES Waiver****	☐ Observation	
☐ Outpatient	☐ **Personal care services***	☐ Skilled nursing facility	☐ Other	

Place of service

☐ Ambulatory surgery center	☐ Home	☐ Independent clinic
☐ Independent lab	☐ Intermediate care facility	☐ Office
☐ School	☐ Hospital	
☐ Other (2-digit code/POS):		

Ordering/referring provider ☐ **Participating** ☐ **Nonparticipating**

Full name: Specialty:

NPI: TIN: Arkansas Medicaid provider ID (PIN):

Contact name: Office phone: Office fax:

Address: City, State ZIP:

Servicing provider ☐ **Participating** ☐ **Nonparticipating**

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** ☐ **Nonparticipating**

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 begin 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 Summit Community Care claims payment policy and procedures.