Arkansas Integrated Providers
AIP DUAL ADVANTAGE
(HMO D-SNP)

Authorization Request Form
Attn: Intake Processing Unit
Phone: 1-833-215-9332
Fax: 1-866-439-0065

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

☐ **EXPEDITE REQUEST: By checking this box, I am stating that waiting for a decision under the standard CMS time frame (7 days) could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy**

Member Name: _____

Member Number: **AR**_____ Date of Birth: _____ / _____ / _____

Requesting Provider Name: _____
Requesting Provider NPI#: _____ Requesting Provider Tax ID#: _____
Servicing Provider/Facility Name: _____
Servicing Provider NPI#: _____ Servicing Provider Tax ID#: _____
Contact Name:_____ Contact Phone:_____ Contact Fax:_____

Requested Service:

- ☐ Inpatient Hospital Admission
- ☐ Psychiatric Inpatient Admission
- ☐ Skilled Nursing Admission
- ☐ Partial Hospitalization
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Medicare Part B Drugs (Antibody and Gene/Cell Therapies only)
- ☐ Cardiac/Pulmonary Rehab, Intensive Cardiac Rehab, or SET for PAD Services
- ☐ Therapeutic/Diagnostic MRI/PET Scans
- ☐ Durable Medical Equipment/Prosthetics
- ☐ Mental Health Specialty Services
- ☐ Outpatient Substance Abuse Services
- ☐ Home Health
- ☐ Psychiatric Services
- ☐ Out of Network Services

Service Dates: _____
ICD: _____ Dx Description: _____
Service Code 1 (HCPCS, CPT, etc.): _____ Service Code 1 Description: _____
Service Code 2: _____ Service Code 2 Description: _____

Quantity / Frequency / Duration (as applicable): _____

☐ **Clinicals are attached to support this case**