SOLIS HEALTH PLANS

Request for Service Authorization

To submit a request, please fax a completed form to: **1-833-210-8141**

To speak to a representative contact Utilization Management Department at: **1-833-615-9260 or local at 305-420-3023**

NOTE: Providers must obtain prior authorization prior to scheduling a service. Please submit clinical information as needed to support the medical necessity for the request. Please make sure this form is completed accurately and completely in order not to delay any service request. ICD-10 and CPT-4 codes should be included. As a reminder, an authorization / certification number is not a guarantee of payment. Payment is subject to verification of, benefit and coverage. We encourage the use of the SOLIS Provider Portal as this will facilitate timely response.

Today's Date:	**Requested date of Service:**
___Standard Request	Solis Health Plans has 14 days from requested date to provide an organizational determination if all sufficient clinical information is received with the request and can be extended an additional 14 days for any additional information needed.
___Expedited Request	Solis Health Plans has 72 hours for all expedited request to render a decision and can extend timeframe for an additional 14 days. The provider must sign the below attestation certifying that applying the standard time frame would seriously jeopardize the life or health of the member.
Date signed:	Physician Signature:

1. MEMBER INFORMATION:

SOLIS Member ID Number:	Member First Name:	Member Last Name:
Date of Birth:	Medicare Number:	Gender: __Male __Female

2. PROVIDER INFORMATION:

Referring (Submitting) Provider	Referring Provider NPI number:	Contact Name: Phone: Fax:
Servicing (Treating) Provider:	Treating Provider NPI number:	Facility NPI number:
Admitting Provider:	Admitting Provider NPI number:	Group Name:

Member ID Number: _____ **v1.1**

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Patient Name: _____ Patient ID Number: _____

3. TYPE OF REQUEST: (Treatment Setting)

Office	Outpatient	Inpatient	Mental Health	Home	Other

4. ICD 10/CPT CODE/HCPCS:

ICD-10	CPT-4 Code/ HCPCS	Date of Service: From / To

5. THERAPY OR REHABILITATION SERVICES:

Date:	Type of Therapy	__PT	__OT	__ST	__Other
Number of Units or Visits Requested:	Initial: _____ Extension: _____ Date(s) Requested: _____	Prior Authorization Number or Certification: _____			

NOTE

PLEASE FAX YOUR ALL REQUESTS FOR HOME HEALTH, DME OR INFUSION SERVICES TO 833-210-8141.

Effective 1/19 v1.1