SOLIS HEALTH PLANS

Request for Service Authorization

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

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

NOTE: Providers must obtain Prior Authorization before scheduling a service.
In order to ensure prompt processing of your request:

- Submit clinical information as needed to support the medical necessity for the request
- In order to timely process the request, make sure this form is completed accurately and completely
- ICD-10 and CPT-4 codes are needed to process the request

FAX ALL REQUESTS FOR HOME HEALTH, DME, OR INFUSION SERVICES TO: 1-833-210-8141
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.

MEMBER INFORMATION				
Member Name:	(Last Name)	(First Name)	**Gender:**	☐M ☐ F
Member Plan ID #:		**DOB:**	____/____/_____	

To be completed by **Provider**

TYPE OF REQUEST			
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:	____/____/_____	**Printed Name:**	
Practitioner's Signature:			

PROVIDER INFORMATION					
Referring (Submitting) Provider Name:		**Referring Provider NPI:**			
Contact Name:		**Phone Number:**		**Fax Number:**	
Servicing (Treating) Provider Name:		**Treating Provider NPI:**			
		Facility NPI:			
Admitting Provider Name:		**Admitting Provider NPI:**			
		Group Name:			

TREATMENT SETTING
Select One: ☐ Office ☐ Outpatient ☐ Inpatient ☐ Mental Health ☐ Home ☐ Other: _____

SERVICE CODES AND DIAGNOSIS		
Diagnosis Code(s)/ICD-10	**CPT Code or HCPC Code**	**Dates of Service: From/To**
		____/____/_____ to ____/____/_____
		____/____/_____ to ____/____/_____
		____/____/_____ to ____/____/_____
		____/____/_____ to ____/____/_____

THERAPY OR REHAB SERVICES			
Select One:	Type of Therapy: ☐ PT ☐ OT ☐ ST ☐ Other:	**Number of Units or Visits Requested:**	
Date(s) Requested:	____/____/_____ to ____/____/_____	Is this request: ☐ Initial or ☐ Extension	
Prior Authorization Number or Certification:			