Hamaspik Medicare

DSNP-MAP Authorization | Service Request

Member Details	**Submitter Details**	**Where would you like for us to send the determination to?** Email ☐ Fax ☐ Mail ☐ **Address:**
Name:	**Submitted by:**	
Date Of Birth:	**Date:**	
Member ID:	**Time Submitted:**	
Primary DX:	**Email:**	
Last Exam Date:	**Fax:**	

Provider Details		**Service Provider Information** *(if different from requesting provider)*	
Requesting Provider Information Name:		**Service Provider Name:** *(Specify Doing Business As (DBA) Name if differs than Name of Provider Specify DBA)*	
Provider Type:	**Phone (include ext.):**	**Provider Type:**	**Phone (include ext.):**
Individual Provider ☐	**Address:**	**Individual Provider** ☐	**Address:**
Group ☐		**Group** ☐	
Hospital ☐		**Hospital** ☐	
STR-SNF ☐	**Fax:**	**STR-SNF** ☐	**Fax:**
DME ☐	**NPI:**	**DME** ☐	**NPI:**
Home Health Agency (HHA|CHHA) ☐	**TIN:**	**Home Health Agency (HHA|CHHA)** ☐	**TIN:**
Other (specify)	**Email:**	**Other (specify)**	**Email:**

Place of Service Details: ***(if different from requesting provider; service provider information)***

In example, if a member is in the hospital requesting a surgery, provider who will conduct surgery will be different than the place of service (hospital)

Facility Information: Name:	**Phone (include ext.):**
Address:	**Email:**
NPI:	**Fax:**
TIN:	**Other:**

Request Type	**Timeframe**	**Frequency** **Units** ☐ **Visits** ☐	**Specifics**
SNF			
DIALYSIS			
INPATIENT HOSPITAL			
Out-Patient Hospital Services			
Out-Patient Diagnostic Procedure (MRI/CT/CAT SCAN)			
CHHA SERVICES:			
Physical Therapy (PT)			
Occupational Therapy (OT)			
Speech - Pathology Therapy (ST)			
RN Services			
HHA Services			
DME			
Other (specify) ***Authorization required for other diagnostic procedures, non-lab tests, and genetic testing procedures***			

Additional Details:

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Specialty Provider Details	**Specify specialty:**	**Other Details:**	
Service Details:	**Date Range of Service(s) Start Date:**	**End date:** *(do not select if this request does not specify an end date to service/benefit)*	
ICD-10(s):		**CPT(s):**	**HCPC(s):**
Reason for Admission (*as applicable):*		**Description of Service Request:**	
Modifier(s): _____	**Other Notes (any other relevant information or details):**		

Attach | Submit all relevant clinical documentation to this request.

Failure to supply the required information may result in a denial of authorization | claims.

Please refer to the Hamaspik Medicare provider manual on our website www.hamaspik.com; 7.1.2 General Requirements for Claims Submissions.

If you have any questions, or updates on your request please contact us at 1-888-426-2774 x608.

Please send completed form and supporting clinical documentation pertaining to this request to:	**MedicareRequests@hamaspikchoice.org**	**Fax: 845-503-1911**

Office Use Only:

Date Received:

Time Received: