Hamaspik Medicare Authorization Request

Member Details

Name:

Date Of Birth:

Member ID:

Date:

Time Submitted:

Submitted by: Fax/Email

Email or Fax info for Authorization:

Requesting Provider Information

Name:

Provider Type (Individual Provider, Group, Hospital, STR-SNF, DME, Home Health Agency, Other (specify):

Phone (include ext.):

Address:

Fax:

NPI:

TIN:

Email:

Where would you like for us to send the Authorization to Email or Fax?

Service Provider Information (if different from requesting provider)

Name:

Provider Type (Individual Provider, Group, Hospital, STR-SNF, DME, Home Health Agency, Other (specify):

Phone (include ext.):

Address:

Fax:

NPI:

TIN:

Email:

Specify Doing Business As (DBA) Name if differs than Name of Provider **Specify DBA:**

Confirm Place of Service Details: (IF DIFFERENT THAN 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:

Fax:

NPI:

TIN:

Email:

Hamaspik
MANAGED CARE

Hamaspik Medicare Authorization Request

Type of Request

SNF ☐

DIALYSIS ☐

INPATIENT HOSPITAL ☐

OUTPATIENT DIAGNOSTIC PROCEDURE (MRI/CT/CAT SCAN) ☐

CHHA SERVICES: PT ☐ OT ☐ ST ☐ HHA ☐ RN ☐ **Details:**

HEARING EXAM ☐

DME ☐

OTHER ☐

SPECIALTY PROVIDER ☐

Specify specialty:

ICD10 and description of reason for admission/service request:

CPT or HCPC or description of requested service:

Date Range of Service(s): Start Date_____ End Date_____

End date (do not select if this request does not specify an end date to service/benefit) **Attach the corresponding clinical documentation to support this request.**

Other Notes (any other relevant information or details):

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, please contact us at 1-888-426-2774.

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: