Triad HealthCare Network
Utilization Management

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PRIOR AUTHORIZATION REQUEST
Custodial Care Benefits Only
*****Form must filled out completely and clinical information attached*****

Submitted by: ❑ Agency	Today's Date: / /
Person to contact for this Submission:	Phone:

Patient's Name:	**DOB:**	**Member ID**:

Requesting Provider Section: (i.e. Provider name not location or facility)	**Servicing Provider Section:** (i.e. Facility or Provider Name, May be the same as Requesting Provider)
Requesting Provider Name:	Custodial Care Agency:
NPI:	NPI:
Tax ID:	Tax ID:
Address:	Address:
Fax:	Fax:
Phone:	Phone:

Date of Admission:	Date of Discharge:
Name of Facility:	

Start of Care Date:	Authorization requests must be submitted within 7 days of the start of care. Retro requests beyond 7 days will be denied. Custodial care hours must be used within 90 days of start of care date.

ICD-10 Code	Diagnosis	ICD-10 Code	Diagnosis
1.		3.	
2.		4.	

	CPT Code	Description	Units/Quantity
X	99509	Custodial Care 1 unit = 15 minutes	20 Hours/80 units

Please document what the custodial care hours will be used for:

This request will be processed per the standard organization determination timeframes. If this request needs to be treated as "expedited", please note clinical justification why applying the standard timeframe for a determination could seriously **jeopardize the member's life, health or ability to regain maximum function:**

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to www.healthteamadvantage.com for specific codes requiring a prior authorization.