Preauthorization Request Form

Humana Musculoskeletal Services

Part 1

Complete and fax this preauthorization request form, including supporting clinical documentation to **857-557-6787.**
For detailed information on Humana's preauthorization requirements, visit **www.humana.com/pal**.

Still faxing? If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the Cohere*Next*:® web portal to manage preauthorizations.
Registration only takes a few minutes, and unlocks access for all users at your practice organization. **Visit www.coherehealth.com/register to begin.**

Patient information

First name **required*

Last name **required*

Member ID **required*

Date of birth (MM/DD/YYYY) **required*

Practice auth contact

Submitter first name **required*

Submitter last name **required*

Submitter email **required if phone number not supplied*

Submitter fax number

Submitter phone number **required if email not supplied*

Diagnosis

Primary diagnosis code **required*

Secondary diagnosis code

Secondary diagnosis code

Service(s) requested

Site of service (please completely fill in one option ⬬) **required*

○ Inpatient ○ Outpatient

Place of service (please completely fill in one option ⬬)

○ 24 Ambulatory Surgical Center
○ 62 Comprehensive Outpatient Rehabilitation Facility
○ 10 Hospital Observation
○ 21 Inpatient Hospital
○ 11 Office
○ Off Campus-Outpatient Hospital
○ On Campus-Outpatient Hospital
○ Other_____

CPT/HCPCS code **required*	Number of units / visits **reqd.*
CPT/HCPCS code	Number of units / visits
CPT/HCPCS code	Number of units / visits
CPT/HCPCS code	Number of units / visits
CPT/HCPCS code	Number of units / visits

Expected date of service (MM/DD/YYYY) **required*

Expected end of service (MM/DD/YYYY)

Ordering physician (or other clinician)

Name **required*

Street address

City

State

Zip code

National Provider Identifier (NPI) **required*

Provider Tax ID number **required*

Fax number

Phone number

Continued on following page

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Performing physician (or other clinician)

○ Use same information from ordering physician (or other clinician) for this section

Name

Street address

City | State | Zip code

National Provider Identifier (NPI) | Provider Tax ID number

Fax number | Phone number

Facility

Facility Name **required*

National Provider Identifier (NPI) **required* | Facility Tax ID number **required*

Expedite request

○ Expedite this request

In order for a case to be expedited the physician (or other clinician) must indicate that applying the standard timeframe could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. If the date of service is greater than 3 days in the future, please DO NOT submit this request as expedited.

Please provide physician (or other clinician) justification

Physician (or other clinician) signature

Please attached relevant clinical documentation after form

Part 2

Preauthorization Request Clinical Worksheet

Orthopedic Surgeries: Hip, Knee, Shoulder Arthroplasty

Complete and fax the clinical worksheet immediately following the preauthorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in question options completely ⬭ → ⬬

Which body site and side is symptomatic? (Fill in all that apply)

- ⬭ Left Shoulder
- ⬭ Right Shoulder
- ⬭ Left Knee
- ⬭ Right Knee
- ⬭ Left Hip
- ⬭ Right Hip