Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Long-Term Services and Supports Authorization Request Form

HealthKeepers, Inc. requests providers submit faxes and attachments for long-term services and supports (LTSS) authorizations. Please fax authorizations to **1-844-864-7853**. Requests may be submitted up to 30 days prior to the expiration of an authorization if the Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) member is eligible.

<table>
<tr><td colspan="3">1. Request type:
☐ New ☐ Change ☐ Renewal ☐ Cancel
If you are changing, renewing or canceling, please note the existing service authorization number.</td></tr>
<tr><td>2. Date of request (MM/DD/YYYY):</td><td colspan="2">3. Review type (check one if applicable):
☐ Retrospective prepayment review
(date notified of eligibility: ____ /___ /_____)
☐ Retroactive MCO enrollment</td></tr>
<tr><td>4a. Member’s HealthKeepers, Inc. ID number:

b. Date of birth (MM/DD/YYYY):</td><td>5. Member’s last name:</td><td>6. Member’s first name:</td></tr>
<tr><td>7. Requesting service provider name:</td><td>a. Address:</td><td>b. NPI:</td></tr>
<tr><td>8. Referring provider name (if applicable):</td><td>a. Address:</td><td>b. NPI:</td></tr>
<tr><td>9. LTSS service authorization type:
☐ Agency-directed
☐ Personal care
☐ Respite care
☐ Consumer-directed
☐ Personal care
☐ Respite care
☐ Personal Emergency Response System
☐ Adult day health care
☐ Service facilitator
☐ Other: _____</td><td>10. Treatment setting:
☐ Home
☐ Adult day health
☐ Other</td><td>11. Primary ICD-10 diagnosis code:</td></tr>
</table>

AVACPEC-0045-17 July 2017

Number	12. HCPCS /CPT procedure code	13. Modifiers (if applicable)	14. Units requested	15. Frequency	16. Days of the week	17. Dates of service	
						From (MM/DD /YYYY)	Through (MM/DD /YYYY)

18. Contact name:

19. Contact telephone number:

20. Contact fax number:

21. Attachments:

☐ *UAI* ☐ *DMAS 96* ☐ *DMAS 97 A/B* ☐ *DMAS 99*
☐ *DMAS 100* ☐ *DMAS 100A* ☐ *DMAS 225* ☐ *DMAS 301*
☐ Copy of previous KEPRO authorization

Additional notes

_____
_____
_____
_____

Instructions for LTSS Authorization Request Form

This faxed submission form is required for new LTSS authorizations, renewals and retrospective reviews. When submitting the fax, please be certain the cover sheet has a confidentiality notice included.

Please complete this form in its entirety. Incomplete forms may result in the case being delayed or returned for additional information. Providers must submit requests for new admissions within 10 business days of the start of care date in order for the request to be timely. Providers must submit a service authorization request if a member requires continued services, if a member has a change in service, or if the current authorization will end. It is the provider's responsibility to track and submit all authorization requests in a timely manner. If you are late in submitting a request, we will review the request and make a determination based on the date it was received. The days and units not submitted in a timely manner will be denied, and appeal information will be provided. Please be aware that standard requests can take up to five business days from receipt of request to complete. Expedited requests can take up to 72 hours from receipt of request, or as necessary based on what the member's condition requires, to complete. This time can be extended up to an additional 14 calendar days if the member or provider request extension.

1. **Request type:**
    - **New:** This is for all new requests. Resubmitting a request after receiving a rejection would also be considered an initial request.
    - **Change:** This is for a change to a previously approved request. The provider may change the quantity of units/dates of service due to either changes in delivery or rescheduling an appointment. If additional units are requested for the same dates of service, enter the total number of units needed (not only the increased amount). Any change request for increased or decreased services must include appropriate justification. The provider may not submit a change request for any item deemed denied or pended.
    - **Renewal:** This is for a request for continued services (items) beyond the expiration of the previous service authorization.
    - **Cancel:** This is for a cancellation of all or some of the items under one service authorization number. An authorization requested under the wrong member number is an example of canceling all lines.
2. **Date of request:** This is the date you are submitting the service authorization request.
3. **Review type:** This is the type of review. Mark the appropriate box. Please refer to the provider manual regarding retrospective review policy and the procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date the provider was notified of retrospective eligibility.

4a. Member's ID number: Enter the member's ID number. It is the provider's responsibility to ensure the member's number is valid.

4b. Date of birth: Enter the member's date of birth in the MM/DD/YYYY format.

5. **Member last name:** Enter the member's last name exactly as it appears on the member ID card.
6. **Member first name:** Enter the member's first name exactly as it appears on the member ID card.

7a. Requesting service provider name and ID number: Enter the requesting service provider name, address and phone/fax numbers.

7b. NPI: Enter the requesting service provider's NPI.
8a. Referring provider name and address: Enter the referring provider name and address if applicable.
8b. NPI: Enter the referring provider's NPI if applicable.
9. Service authorization type: Enter the category of service you are requesting.
10. Treatment setting: Enter the place of service.
11. Primary diagnosis code/description: Enter the primary diagnosis code and/or description indicating the reason for service(s). Use the appropriate ICD-10-CM code and enter up to four diagnoses.
12. HCPCS/CPT code: Enter the HCPCS/CPT procedure code.
13. Modifiers: Enter up to four modifiers as applicable. Durable medical equipment (DME) providers: Enter modifier as appropriate based upon the DME and Supplies Listing/Appendix B found in the *Department of Medical Assistance Services DME Provider Manual*.
14. Units requested: Enter the number of hours/visits requested. These are based on *DMAS 97 A/B* plan of care and use only numerals for this field.
15. Frequency: Enter the usage frequency of service requested (for example, weekly, biweekly, annually).
16. Days of the week: This is for adult day health or other services as applicable.
17. Dates of service: Enter the planned service dates using the MM/DD/YYYY format. The from and through dates must both be completed even if they are the same date. You may enter dates for up to one year.
18. Contact name: Enter the name of the person to contact if there are questions regarding this fax form.
19. Contact telephone number: Enter the phone number (including area code) of the contact named above.
20. Contact fax number: Enter the fax number (including area code) to use if there is a denial/rejection.
21. Attachments: Enter the attachments sent with the request. Reference the *LTSS Authorization Guide* for specific attachment requirements.

Providers are responsible for verifying eligibility, benefits and their participation status before providing services to members. Failure to obtain prior authorization for services (except for a member's initial enrollment under continuity of care) may result in a denial for reimbursement.

This form is not required for services covered under continuity of care as existing authorizations will be honored for up to 90 days or until the authorization ends (whichever is sooner). The duration is dependent on whether it is the member's initial enrollment or re-enrollment.

Please note, an authorization is not a guarantee of payment. It is subject to the member's eligibility and contractual limitations as of the date of service. If payment is appropriate under the terms and conditions of an eligible member's contract, payment will be made at the provider's contracted rate or 100% of the established rate for the service fee scheduled for noncontracted providers.