

To submit a request, please fax a completed form to 833-210-8141.

To speak to a representative, contact the Utilization Management Department at: **833-615-9260**

Note: Providers must obtain prior authorization prior to scheduling a service. Please submit clinical information as needed to support the medical necessity for the request. Please make sure this form is completed accurately and completely in order not to delay any service request. ICD-10 and CPT codes should be included. As a reminder, an authorization or certification number is not a guarantee of payment. Payment is subject to verification of benefit and coverage. We encourage the use of the Solis Provider Portal as this will facilitate timely response.

Please fax all requests for home health, DME, or infusion services to IHCS to: **844-215-4265**.

To speak to a representative, contact them at: **844-215-4264**.

Request Type	
Standard Request ☐	Solis has 7 days from requested date to provide an organizational determination if all sufficient clinical information is received with the request and can be extended an additional 7 days for any additional information needed.
Expedited Request* ☐	Solis has 72 hours for all expedited requests to render a decision and can extend timeframe for an additional 14 days. <i>*By checking this box, the Provider must sign the below attestation certifying that applying the standard time frame would seriously jeopardize the life or health of the member.</i>
Date Signed:	
*Physician Signature:	

For Part B Injectable Requests	
All HCPCS Level II requests for medications covered under Medicare Part B must include a valid treatment plan at the time of submission.	
Standard Request ☐	Solis has 72 hours from requested date to provide an organizational determination if all sufficient clinical information is received with the request and can be extended an additional 7 days for any additional information needed.
Expedited Request* ☐	Solis has 24 hours from requested date to provide an organizational determination if all sufficient clinical information is received with the request and can be extended an additional 14 days for any additional information needed. <i>*By checking this box Provider must sign below attestation certifying that applying the standard time frame would seriously jeopardize the life or health of the member.</i>
Are you a contracted BUY and BILL Provider ? ☐ Yes ☐ No	
Date Signed:	
*Physician Signature:	

Member Information

Member First Name:	Member Last Name:
Date of Birth:	Gender: ☐ Female ☐ Male
Solis Member ID Number:	Medicare Number:

Provider Information

Referring (Submitting) Provider:	Referring Provider NPI AND Tax ID Number:	Contact Information (Required): Contact Name: Phone: Fax:
Servicing (Treating) Provider:	Servicing Provider NPI AND Tax ID Number:	Facility NPI AND Tax ID Number
Admitting Provider:	Admitting Provider NPI AND Tax ID Number:	Group Name:

Type of Request (Treatment Setting)

☐ Office	☐ Post Acute Level of Care (LOC)
☐ Outpatient	☐ Skilled Nursing Facility (SNF)
☐ Inpatient Levels of Care (LOC)	☐ Inpatient Rehab Facility (IRF)
☐ Observation	☐ Long Term Acute Care (LTAC)
☐ Behavioral Health - Psychiatric Admission	☐ Mental Health
☐ Elective (Voluntary)	☐ Home
☐ Baker Acted (Involuntary)	☐ Other:
☐ Inpatient - Medical	

Certified Treatment Period**Treatment Start:****Treatment End:****ICD-10/CPT Code/HCPCS****

ICD-10	CPT Code/ HCPCS	Date of Service: From/To	Dose	Frequency	# of Treatments	Units	Visits

****For all requests, please attach medication orders.**

Solis Health Plans may limit authorization time frames to three (3) months.

Therapy or Rehabilitation Services**Date:****Number of Units/Visits Requested:****Type of Therapy:** ☐ PT ☐ ST ☐ OT ☐ Other**Prior Authorization Number or Certification:****Initial:****Extension:****Date(s) Requested:****Notes:**