Inner Sanctum Massage Pre-Authorization Form

COMPLETE ALL INFORMATION ON THIS FORM. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to Inner Sanctum Massage. Call 757-637-0189

Health Plan:	**Health Plan Fax #:**	***Date Form Completed and Faxed:**

Service Type Requiring Authorization[1, 2, 3] (*Check all that apply*)

Ambulatory/Outpatient Services	**Ancillary**	**Dental**	**Durable Medical Equipment**
☐ Surgery/Procedure (SDC) ☐ Infusion or Oncology Drugs	☐ Acupuncture ☐ Chiropractic ☐ IVF/ART ☐ Non-Participating Specialist	☐ Adjunctive Dental Services ☐ Endodontics ☐ Maxilliofacial Prosthetics ☐ Oral Surgery ☐ Restorative	☐ Prosthetic Device ☐ Purchase ☐ Renal Supplies ☐ Rental
Home Health/Hospice	**Inpatient Care/Observation**	**Nutrition/Counseling**	**Outpatient Therapy**
☐ Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) ☐ Hospice ☐ Infusion Therapy ☐ Respite Care	☐ Acute Medical/Surgical ☐ Long Term Acute Care ☐ Acute Rehab ☐ Skilled Nursing Facility ☐ Observation	☐ Counseling ☐ Enteral Nutrition ☐ Infant Formula ☐ Total Parental Nutrition	☐ Occupational Therapy ☐ Physical Therapy ☐ Pulmonary/Cardiac Rehab ☐ Speech Therapy
Transportation ☐ Non-emergent Ground ☐ Non-emergent Air	☐ **Other—please specify:**		

Provider Information (Denotes required field*)**

***Requesting Provider Name and NPI#:**	***Phone:**	**Fax:**
***Servicing Provider Name and NPI# (and Tax ID if required):** ☐ *Same as Requesting Provider*	***Phone:**	**Fax:**
***Servicing Facility Name and NPI#:** ☐ *Same as Requesting Provider*	***Phone:**	**Fax:**
***Contact Person:**	***Phone:**	**Fax:**

Member Information (Denotes required field*)**

***Patient Name:**	***☐ Male ☐ Female**	***DOB:**
Health Insurance ID#:** ***If other insurance, please specify:	***Patient Account/Control Number:**	
Address:	**Phone:**	

Diagnosis/Planned Procedure Information (Denotes required field*)**

***Principal Diagnosis Description:** **ICD-9 Codes:**	***Principal Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** ☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage
Secondary Diagnosis Description: **ICD-9 Codes:**	**Secondary Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** ☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage
***Service Start Date:**	***Service End Date:**

[1] Please attach plan specific templates that are required for supporting clinical documentation.
[2] Not all services listed will be covered by the benefits in a member's health plan product.
[3] This form does not replace payer specific prior authorization requirements.