SUNRISE ADVANTAGE PLAN

Authorization No: ____________________ Date: __________ SAP Reviewer: ________________________________

REQUEST FOR OUTPATIENT THERAPY
AUTHORIZATION OF SERVICES FORM – SINGLE CASE

Email form, order and Clinical screen to UMInquiryRequest@sunriseadvantageplan.com, or Fax to: 800-504 4752

Call UM at: (IL) 844-502-4149 opt. 3 or (NY, PA, VA) 844-896 0628 opt. 3
(Call Center Hours M-F 8am-5pm)

*****PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS IN ONE EMAIL – MUST SEND SEPERATELY**

☐ **STANDARD AUTHORIZATION** ☐ **EXPEDITED/REVIEW (72 Hours)**

***PRIOR WRITTEN AUTHORIZATION IS REQUIRED BEFORE THE START OF SERVICES FOR OUTPATIENT REHAB AND FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Member Handbook/Certificate of Coverage. A copy of this Authorization Form must be submitted with the claim.

Member Demographics

______________________________ ________________ ______________________
Member Name **Date of Birth** **Member's Plan ID**

______________________________ ________________
Name of Sunrise Community or Other **Referring Provider**

Is referring provider: ☐PCP/AP ☐Other

Outpatient Therapy

Diagnoses (ICD-10 Codes) Related to Authorization Request:____

REQUEST DATE: ______________________ **SERVICE ANTICIPATED START DATE:** ____________

Provider Company Name **(REQUIRED)**: ______________________ Provider Requesting Name (**REQUIRED**): ______________

Provider Contact Number (**REQUIRED**): __________________ Provider Email (**REQUIRED**): __________________________

Provider Fax Number (**REQUIRED**): ________________________

☐ OUTPATIENT THERAPY (Check Applicable Service(s))			
Routine Case Rate (up to 8 Visits/One Therapy: OT or PT)		**Complex Case Rate (8 Visits or more; 2 or more Therapies)** **Note: ST will need another discipline to also evaluate**	
Safety Training		Rehab post joint replacement	
New adaptive equipment		Rehab post hip fracture/ major fracture	
Identified fall risk for fall without injury		S/P fall with injury or multiple falls	
Changing and Maintaining Body position		Post-Hospitalization	
Pain Management		Wound Care	
Medication Management		ST: Voice Functional limitation	
Personal Care Training		ST: Swallowing	
Carrying, Moving, Handling objects		ST: Motor Speech	
Mobility: Walking and moving around functional limitations		ST: Spoken language comprehension	
Other:		ST: Attention Functional limitations	
		ST: Memory Functional limitations	
		Other:	

Notes: