

Instructions: Please use this form only for the services and procedures listed on the second page (see other PA forms for requests not included here).

ONLY COMPLETED FORMS CAN BE PROCESSED

Harvard Pilgrim reserves the right to request additional clinical information.
Incomplete forms or lack of supporting documentation may delay response time.

Please check the box below only if request meets the definition of "expedited."

- ☐ Expedited: Medicare defines expedited requests as those where "applying the standard time for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function."

Patient Information	Person Completing Form
Patient name:	Name:
HPHC member ID #:	Phone #:
Date of birth:	Fax #:
Requesting Provider/Facility	Servicing Provider/Facility
Last name: _____	Last name: _____
First name: _____	First name: _____
Title (NP, PA): _____	Title (NP, PA): _____
HPHC provider ID #:	Address:
NPI #:	
Service start date: _____	HPHC provider ID # (if known)
Service end date: _____	
Diagnosis:	Tax ID #:
ICD-10 code:	
Service type: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observation <input type="checkbox"/> Other	Number of visits/units requested:
Service location:	Authorization type:
Procedure code(s)	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Please attach any applicable clinical documentation.

If you have any questions about this process, please contact the Medicare Advantage Provider Service Center at
888-609-0692.

(Continued)

Service(s) Requested: (check appropriate request(s) and attach supporting clinical documentation).

Cosmetic (Reconstructive and Restorative procedures)

☐ **Chest Surgeries**

- ☐ Repair of Pectus Excavatum
- ☐ Repair of Pectus Carinatum
- ☐ Repair of Chest Wall Deformity for Poland Syndrome
- ☐ Breast Implant Removal and/or Revision
- ☐ Breast Reconstruction

☐ **Eye Procedures**

- ☐ Brow Ptosis Repair
- ☐ Lower Blepharoplasty
- ☐ Upper Blepharoplasty
- ☐ Upper Blepharoptosis Repair

☐ **Nasal Procedures**

- ☐ Rhinophyma Treatment
- ☐ Rhinoplasty
- ☐ Septoplasty

☐ **Gynecomastia Surgery**

- ☐ Diagnostic
- ☐ Corrective

☐ **Inpatient Hospital** (*see other forms for select surgical procedures*)

- ☐ Elective – prior authorization
- ☐ Emergent – notification only
- ☐ Observation – notification only

☐ **TMJ (Temporomandibular Joint) Disorders**

- ☐ Therapeutic Arthroplasty/Arthrotomy including Discectomy
- ☐ Joint Replacement
- ☐ Therapeutic Arthroscopy

☐ **Varicose Vein Treatment**

- ☐ Ambulatory Phlebectomy
- ☐ Endovenous Laser Ablation
- ☐ Endovenous Radiofrequency Ablation (EFRFA)
- ☐ Ligation and Stripping
- ☐ Sclerotherapy
- ☐ Subfascial Endoscopic Perforator Vein Surgery (SEPS)
- ☐ Transilluminated Powered Phlebectomy (TIPP)