



Service Authorization Request (SAR) Manual Authorization Request Form

When to Use This Form

Use this form only when a request cannot be submitted through ProAuth/TruCare. This form may be used when:

1. **ProAuth/TruCare is unavailable** and is not expected to be available for an extended period, such as four hours or more. Partners will communicate extended system outages on the Partners website.
2. **The requesting provider is out-of-network or non-participating** and is serving a Partners member who:
 - Requires specialty treatment unavailable in the Partners network
 - Is outside the Partners catchment area when a crisis occurs
 - Lives outside the Partners service area but continues to have Medicaid from one of Partners' counties
3. **The requested service is not listed in the Partners Benefit Plan** and is not available as a drop-down option in ProAuth/TruCare. For example, an EPSDT Medicaid request for a service not covered by Partners.

Instructions for Completion

I. General Information

1. **Prepaid Health Plan (PHP) Name** - Partners Health Management is prefilled.
2. **Member Name** - Enter the member's name. If the member has Medicaid, enter the name as it appears on the NC Medicaid Identification Card.
3. **Date of Birth** - Enter the member's date of birth.
4. **Address** - Enter the member's street address, city, state and ZIP code.
5. **NC Medicaid ID Number/CNDS Number** - Enter the member's NC Medicaid Identification number as shown on the NC Medicaid Identification Card or county letter of eligibility or enter the CNDS number.
6. **Diagnosis Code** - Enter the diagnosis code or codes.
7. **Diagnosis Description** - Enter all diagnoses and include all descriptions related to the services being requested.
8. **Service Location** - Enter the name and address of the facility where services will be provided, if the service will be provided somewhere other than the member's home or provider's office.

II. Service Information

9. **Reference Number** - Enter a unique reference number (1-12) for each line on the request.
10. **Procedure Code** - Enter the procedure code for the service being requested.
11. **From** - Enter the date services should begin if authorization is approved. Use MM/DD/YY format.
12. **To** - Enter the date services should end if authorization is approved. Use MM/DD/YY format.
13. **Description of Service/Item** - Enter a specific description of the service, item, equipment, procedure or prosthesis being requested.
14. **Quantity or Units** - Enter the quantity or number of units being requested.
15. **Medical Necessity Explanation** - Provide a detailed explanation of medical necessity and required supporting documentation. Attach additional pages as needed.
 - **Required Supporting Documentation**
 - For behavioral health services, attach applicable clinical documentation, such as:
 - Current Comprehensive Clinical Assessment (CCA)
 - Diagnostic Assessment (DA)
 - Level of Care Utilization System (LOCUS) or Child & Adolescent Level of Care Utilization System (CALOCUS) score

- Other clinical or psychiatric evaluations
- For State-funded I/DD service requests, attach the North Carolina Support Needs Assessment Profile (NC SNAP)
- For substance use disorder service requests, attach the American Society of Addiction Medicine (ASAM) Level of Care determination
- **Do not use another prior authorization form for these requests.**

III. Provider Requesting Prior Authorization

16. **Provider Name** - Enter the requesting provider's information. If the provider is a clinic or group practice, also complete Section IV.
17. **NPI** - Enter the requesting provider's National Provider Identifier.
18. **Address** - Enter the requesting provider's complete mailing address.
19. **Telephone** - Enter the requesting provider's telephone number, including area code.
20. **Fax/Email** - Enter the requesting provider's fax number, including area code and email address.

IV. Prescribing/Performing Practitioner

Complete this section for services that require a prescription, such as durable medical equipment or physical therapy, or for services prescribed by a physician or practitioner that require prior authorization. Also complete this section when the provider listed in Section III is a clinic or group practice.

21. **Name** - Enter the name of the prescribing or performing practitioner.
22. **Telephone** - Enter the practitioner's telephone number, including area code.
23. **Address** - Enter the practitioner's address, including city, state and ZIP code.

V. For Plan Use Only

Partners will indicate approval or denial for each requested line in the "For Plan Use Only" area of Section II.

If the procedure requires manual pricing, Partners will also indicate the allowed amount. Partners may include denial explanations or notes by referencing the applicable reference number from Section II. The reviewer will sign or initial the form.

How to Submit the Completed Form

Submit the completed Manual Authorization Request Form and all required supporting documentation using one of the methods below.

Email - Email may be used only if the message is encrypted.

- Behavioral Health, I/DD and TBI requests: BHIDDManualAuthorizations@partnersbhm.org
- Out-of-network manual prior authorization requests: Providers@partnersbhm.org
- Physical health requests: PHManualAuthorizations@partnersbhm.org

Fax - Fax is for PH/PADP requests only.

- Inpatient physical health requests: **336-527-3208**
- Outpatient physical health requests: **704-884-2613**
- Transplant requests: **866-753-5659**
- Pharmacy PADP requests: **704-772-4300**

Mail or Hand Delivery

Partners Health Management
 Attn: UM Department
 901 South New Hope Road
 Gastonia, NC 28054



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Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be NC Medicaid eligible on the date of service or date the equipment or prosthesis is received by the beneficiary.

I. General Information			
1. PHP Name:	Partners Health Management		
2. Member Name:			
	<i>Last</i>	<i>First</i>	<i>MI</i>
3. Date of Birth:			
4. Member Address:			
	<i>Street</i>		
	<i>City</i>	<i>State</i>	<i>Zip Code</i>
5. NC Medicaid ID/CNDS Number:			
6. Diagnosis Code:			
7. Diagnosis Description:			
8. Service Location:			
	<i>Facility Name</i>		
	<i>Street</i>		
	<i>City</i>	<i>State</i>	<i>Zip Code</i>

II. Service Information						For Plan Use Only	
9. Ref. No.	10. Procedure Code	11. From	12. To	13. Description of Service/Item	14. QTY or Units	Approved /Denied	Amt. allowed if priced by report
(1)						Choose O	
(2)						Choose C	
(3)						Choose C	
(4)						Choose C	

Ref. No.	Procedure Code	From	To	Description of Service/Item	QTY or Units	Approved /Denied	Amt. allowed if priced by report
(5)						Choose O	
(6)						Choose O	
(7)						Choose O	
(8)						Choose O	
(9)						Choose O	
(10)						Choose O	
(11)						Choose O	
(12)						Choose O	

15. Provide a detailed explanation of medical necessity and required supporting documentation. Attach additional pages if necessary.

III. Provider Requesting Prior Authorization

By submitting this form, the provider identified in Section III certifies that the information provided in Sections I, II and III is true, accurate and complete.

16. Provider Name:		
	<i>Last</i>	<i>First</i>
17. NPI:		
18. Provider Address:		
	<i>Street</i>	
	<i>City</i>	<i>State</i> <i>Zip Code</i>
19. Phone:		
20. Fax/Email:		

IV. Prescribing/Performing Practitioner

Complete this section when:

- The service requires a prescription, such as durable medical equipment or physical therapy.
- The service will be prescribed by a physician or practitioner and requires prior authorization.
- The provider listed in Section III is a clinic or group practice.

21. Practitioner Name:				
	<i>Last</i>		<i>First</i>	
22. Phone:				
23. Address:				
	<i>Street</i>			
	<i>City</i>	<i>State</i>	<i>Zip Code</i>	

V. For Plan Use Only

Denial reason(s): Refer to the reference number listed in Field 9.

Ref. No.	Denial Reason/Notes		
If approved:			
Services authorized to begin:		Today's Date:	
Reviewer Name:			
Reviewer Signature:			



Supplemental Manual Authorization Request Form (Optional)

Complete this supplement only if the information applies to the request. Authorization approves the medical necessity of the requested services only. It does not guarantee payment, and it does not guarantee that the amount billed will be the amount reimbursed. The member must have NC Medicaid eligibility on the date of service or on the date the equipment or prosthesis is received.

Optional Information					
Member Name:					Member ID:
	<i>Last</i>		<i>First</i>		
Expedited Request:	☐ Yes ☐ No	Request Type:	☐ Initial ☐ Reauthorization		
Service Type:	☐ I/DD ☐ MH ☐ SUD ☐ PADP ☐ Transplant ☐ PH				
Status:	☐ Voluntary ☐ Involuntary				
Legal Guardian Information					
Guardian Name:					Relationship:
	<i>Last</i>		<i>First</i>		
Substance Use Disorder					
Substance:	Priority:	Age of First Use:	Route of Use:	Frequency:	Amount:
(1)					
(2)					
(3)					
(4)					
(5)					
Medical Information:					
PCP Name:					
	<i>Last</i>		<i>First</i>		
Compliance:	☐ Medically compliant ☐ Medically non-compliant				
Comments:					
☐ Signed release to primary physician attached					

Physical Health Information:

Comments:

Medication Information:

Medication Name:

Dosage:

Regimen:

Num. of Refills:

Supporting Documents Attached

Check all that apply:

☐ CCA ☐ DA ☐ NC SNAP/SIS ☐ Psychological/Psychiatric Evaluation ☐ ASAM☐ School Records ☐ PCP/ISP ☐ Medical Records ☐ Treatment Plan☐ Other: _____