

3.2 a Sample Service Plan Letter (Page 1)

<<today_date_mm_ddyyyy>>

«PROV_FIRSTNAME» «PROV_LASTNAME»
«PROV_ADDRESS1»
«PROV_ADDRESS2»
«PROV_CITY» «PROV_STATE» «Prov_ZipCode»

Member Name: <<m_full_name>>
Member ID: <<m_id>>
Level of Care: <<Level I, Level II>>
Authorization Number: <<re_authorization_number>>
Approved Services:

<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>

SERVICE AUTHORIZATION

Dear «Prov_Firstname» «Prov_Lastname»:

Senior Health Partners has reviewed the request for service(s) for the member referenced above. Based on the information received, it has been determined that the service(s) are medically necessary and appropriate and therefore are approved. Senior Health Partners must be notified of any changes relating to the treatment plan or services approved.

This approval covers the period from <<re_referral_start_date>> to <<re_referral_end_date>>. The service(s) above are approved as part of the member's plan of care. We will review the plan of care again at least every six (6) months or sooner if there is a change in the member's health status or service needs.

Providers may not bill Senior Health Partners members under any circumstances for approved covered services.

This assessment of care has been made for coverage purposes and does not supersede the professional judgment of the provider of care. In all situations, the final decision regarding medical treatment remains with the provider and patient.