CareAffiliate® Guide

Using CareAffiliate at www.tricare-west.com

Use this guide to assist you in using CareAffiliate – Health Net Federal Services, LLC's (HNFS') online referral and authorization submission tool for the TRICARE West Region. Use CareAffiliate for both outpatient and inpatient requests.

All TRICARE West Region referral and authorization requests must be submitted online.

Remember … Not all specialty services require a referral or authorization. Use our online **Prior Authorization, Referral and Benefit** (PARB) tool, our **Ancillary Services Approval Requirements** tool, and our **Benefits A–Z** pages to quickly and easily determine whether an HNFS approval is needed. If the service doesn't require HNFS approval, then there's nothing to submit. You can print your results from PARB for your patient files.

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Section 1: Getting Started

To use this tool, you'll first need to log in to **www.tricare-west.com**, as requests submitted are tied to the provider Tax Identification Numbers (TINs) associated with your **www.tricare-west.com** account.

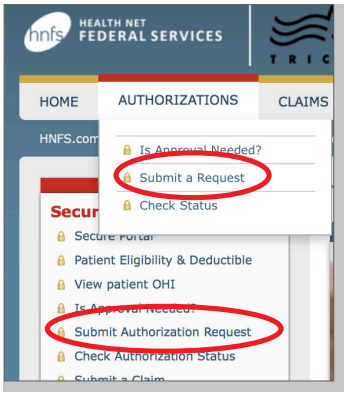
Helpful tips

- Use Google Chrome or Microsoft Edge for best results.
- Clear all cookies.

1. **Log in to the secure provider portal.** If you do not yet have a username/password, click the "Register" link to learn more.

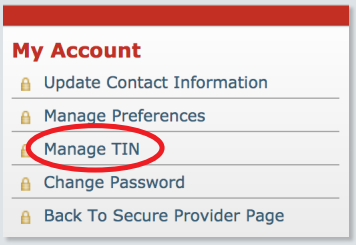
Note: *Passwords expire after 365 days. To set a new password, just follow the change password prompts.*

2. **Click on Submit Authorization Request.**
Locate this link in the **Secure Tools** box in the left navigation pane and in the **Authorizations** tab drop-down menu. Both links take you to the same place.



3. **You will be re-directed to CareRadius.**
CareRadius is a sub-set of CareAffiliate.

Why Tax Identification Numbers are Important



Your web registration account is linked to your provider Tax Identification Number or TIN. Without this link, you will be unable to select a requesting provider within CareAffilate and therefore, be unable to submit the request.

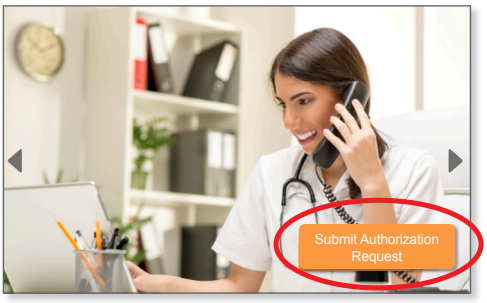
To determine which TIN your registration is linked to, go to the top or left navigation and click on **My Account** > *Manage TIN* to display the provider TIN or TINs that are linked to your account. From here, you can also add additional TINs to your account. Just like when you initially registered on the website, to add TINs you'll need two claim or authorization numbers.

Section 2: Submit a Request

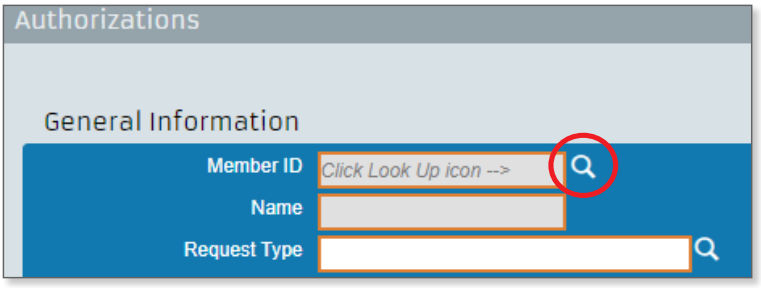
Here are some tips to keep in mind:

- There are multiple ways to search: magnifying glass icon, drop-down menus, “type-ahead” fields, and “wild card” searches using asterisks.
- Certain fields, such as member and requesting provider, have links displayed to the left that allow you to view more details.
- Fields outlined in orange are required fields. If a field is grayed out, it means it is locked and cannot be edited.

1. Click on **Submit Authorization Request.**

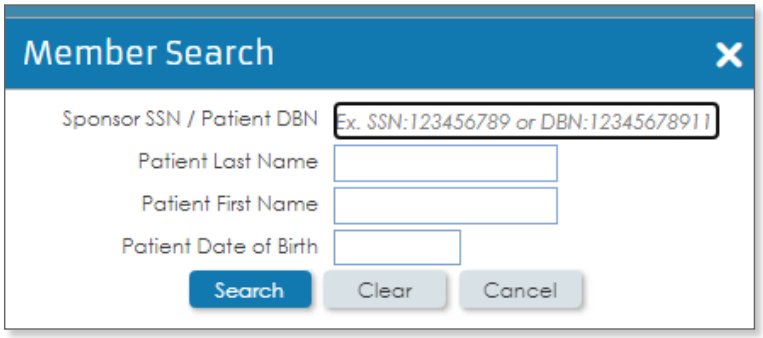


2. Search for a member. Click on the magnifying glass symbol to **start your search.**



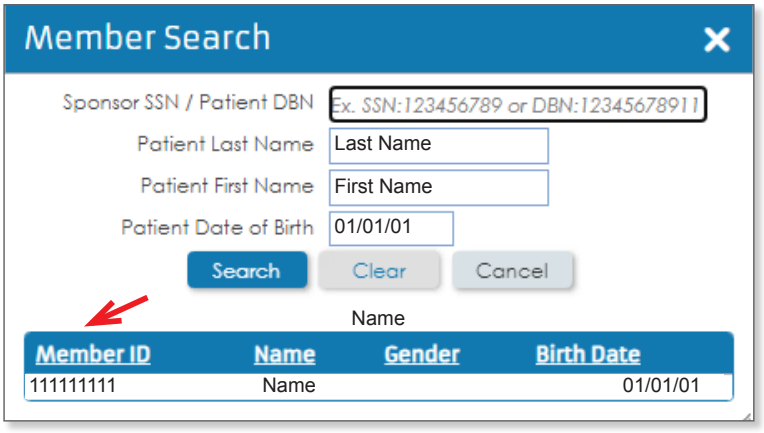
3. **Enter in the patient’s information.** All fields are required.

Tip: *Be sure to enter the patient’s date of birth in the 2-digit month, 2-digit day and 4-digit year format.*

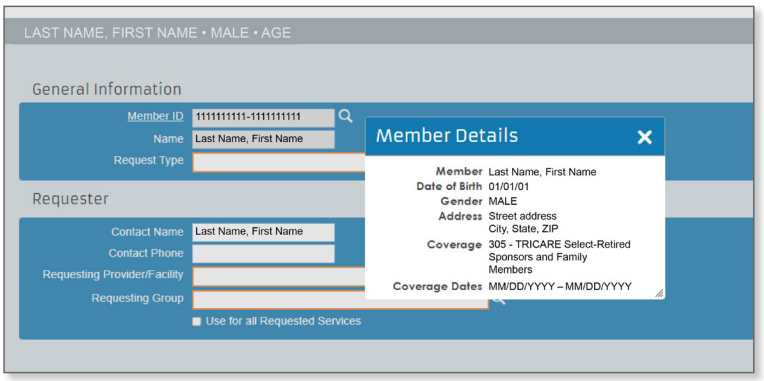


Section 2: Submit a Request *(continued)*

4. Select the beneficiary.

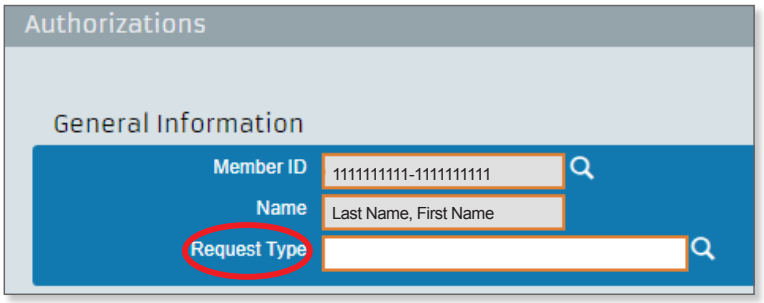


5. Verify the beneficiary information by clicking on "Member ID." If changes are required, refer to step 21.



6. Enter the request type. Request types are templates created by HNFS for referral and authorization submissions. Each request type has specified codes/code ranges that will pre-populate in the request.

Tip: *Do not use "Evaluate and Treat" request types for therapies (for example, physical therapy) or mental health services.*



Section 2: Submit a Request *(continued)*

The easiest way to find the appropriate request type is by using the **Request Types** charts.

Request Types

The associated codes/code ranges, number of visits, and duration of the authorization will populate based on the request type selected.

To view the different request type tables, click on the appropriate category:

Outpatient specialty referrals
(provider to provider)
Outpatient authorizations
- physical health
- behavioral health

Durable medical equipment
Inpatient authorizations

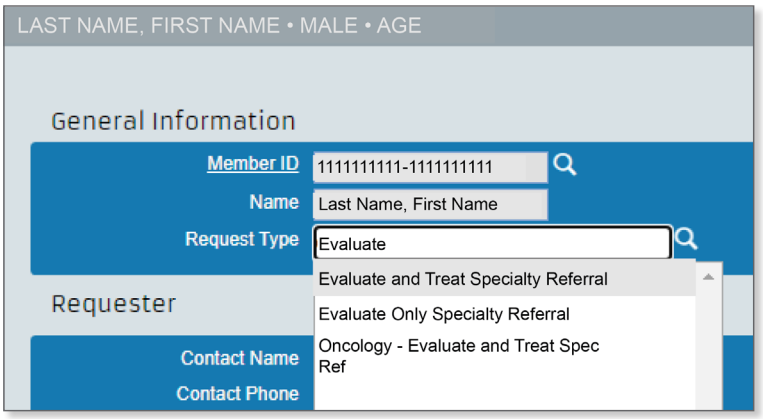
Description	Included CPT® Code(s)	Request Type	Approval Duration
Evaluate and Treat Specialty Referral	99202–99205, 99211–99215, 99242–99245	P1	180 days for ADSMs 365 days for non-ADSMs
Evaluate Only Specialty Referral	99202–99205, 99211–99215, 99242–99245	P3	180 days
Oncology – Evaluate and Treat Spec Ref	99202–99205, 99211–99215, 99242–99245	P6	365 days
Pre/Post Transplant	99211–99215, 99242–99245	P58	360 days for codes 99211–99215 90 days for codes 99242–99245

(Sample)

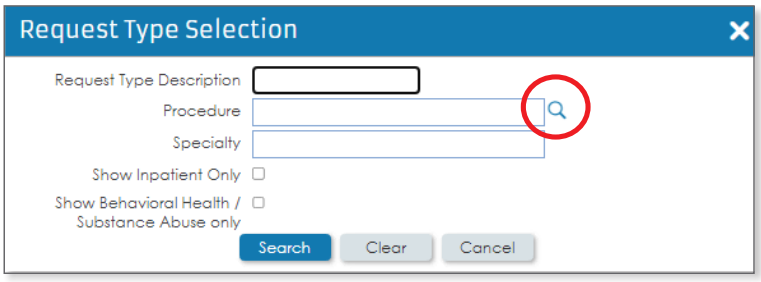
Also see *Section 3: Request Types/Adding Codes.*

Below are two ways to search for a request type.

a. Type the request type description into the **Request Type** box and select the appropriate request type. (For example, start typing the word "evaluate" and a drop-down menu will display.)



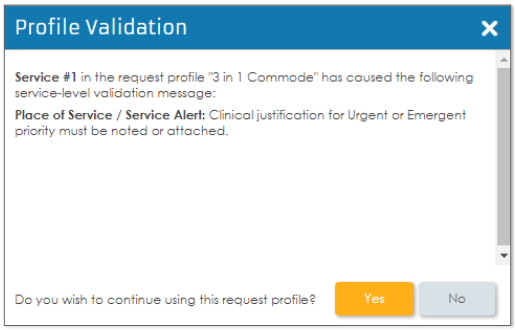
b. When the Request Type Description window pops up, all request types available will appear automatically. However, you can still search for the needed request type. If you aren't sure what request type you need based on the request type charts, click on the magnifying glass to display the **Request Type Selection** search box.



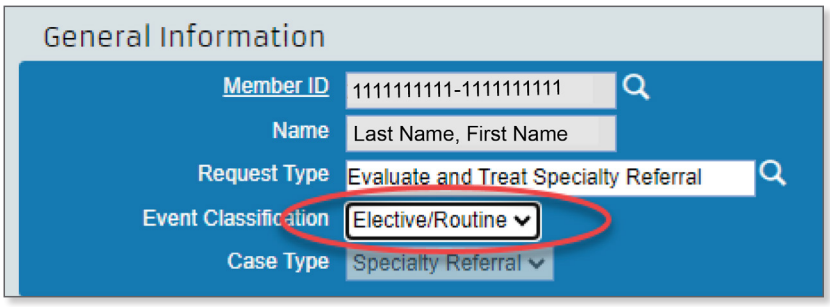
Click on the magnifying glass to the right of the **Procedure** box. Another box will appear; enter in a CPT®, NDC, or HCPCS code in the **Code** box and click the **Search** button to view a description and/or select the procedure. If the code you entered is included in one of our request types, those request types will be displayed and you can choose the appropriate option. If a request type does not display, you must then choose an appropriate generic request type. (See *Section 3: Generic Request Types/Adding Codes*)

Section 2: Submit a Request *(continued)*

7. **Review the profile validation message** (if applicable).
Pay close attention to these types of messages!
They may require you to do additional actions prior to submitting your requests.

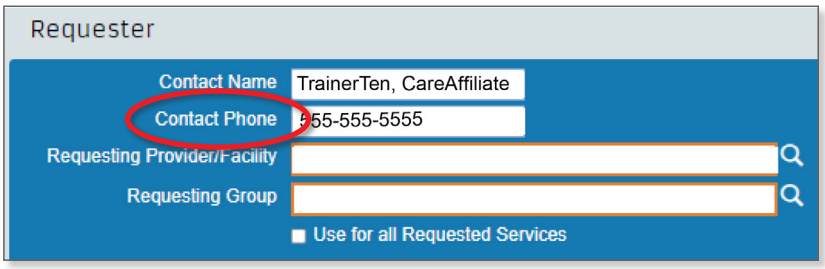


8. **Select the event classification.**

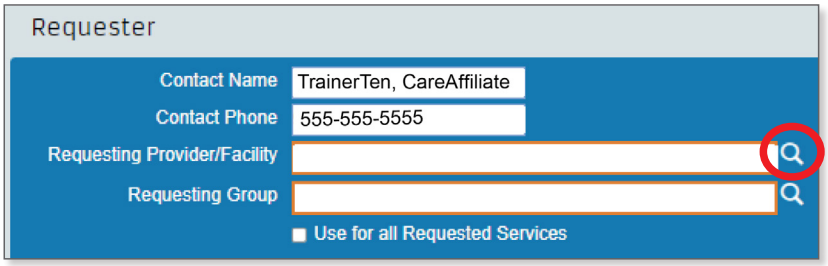


Tip: *Use* ***Elective/Routine*** *when care is needed within the four-week TRICARE specialty care access standards. Nearly all referral requests are routine unless the patient needs care in less than 72 hours; use* ***Urgent*** *when care is needed within 24–72 hours; and use* ***Emergency*** *when care is needed within 24 hours or less.*

9. **Input your phone number in the "Contact Phone" field.** The contact information included here is the contact information of the person who is submitting the request.

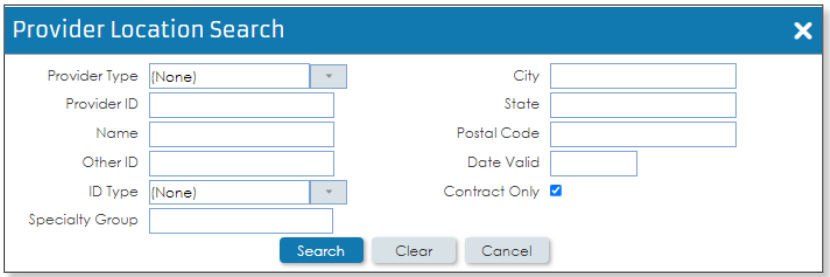


10. **Select a requesting provider/facility or group.** Start by clicking on the magnifying glass.



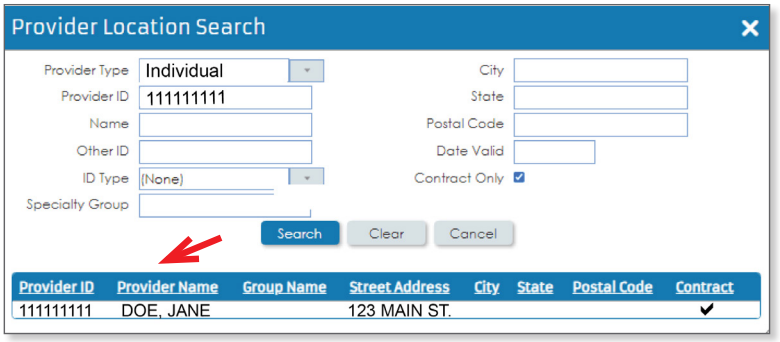
Tip: *"Provider/Facility" = individual provider, "Group" = medical group (includes DME, home health and laboratory providers). You only need to enter provider/facility OR group for outpatient specialty referrals.*

11. **Search for the requesting provider by TIN, name, or other filters to narrow your search.** *All the TINs associated with your web account will display. (See "Why Tax Identification Numbers are Important" on page 2.)*

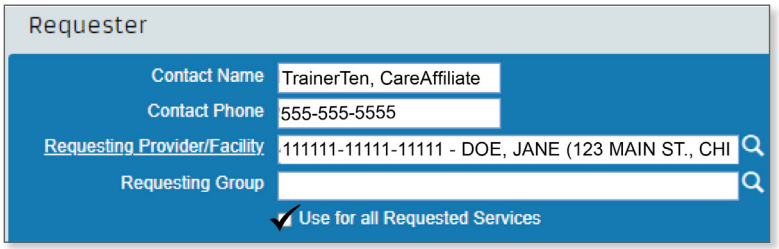


Section 2: Submit a Request *(continued)*

12. Select a requesting provider location. Choose from the drop-down menu or use other filters to narrow your search.

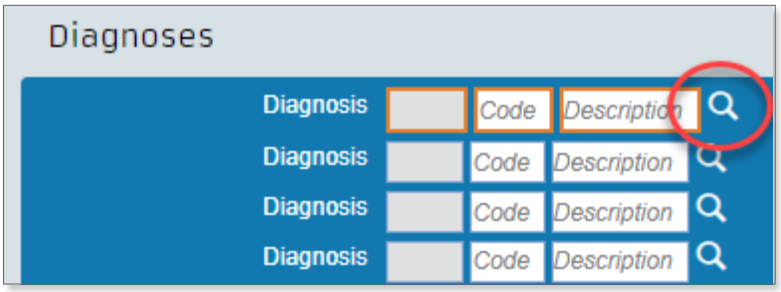


Once you select a record, the provider information will populate.

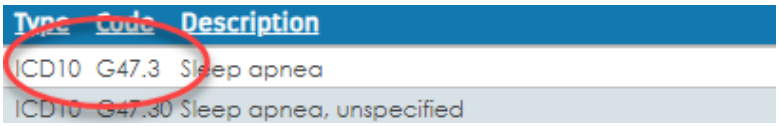


Tip: *If the requesting provider is also going to be the servicing provider, check the "Use for all Requested Services" box.*

13. Enter the diagnosis. Enter in your ICD-10 code or click on the magnifying glass if you don't have a code.

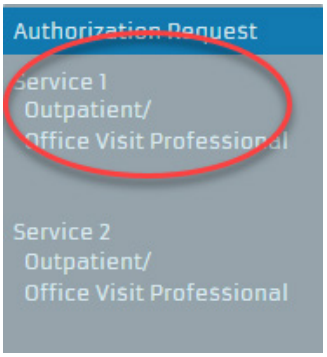


Always select ICD-10 codes, even if ICD-9 codes show in the drop-down menu or search results.



Tip: *CareAffiliate lets you add up to four diagnosis codes, with the first diagnosis considered to be primary. If there are additional codes, enter them in the Notes feature in the left navigation blue section.*

14. Select a service line from the left navigation blue section.
The request type selected determines the number and type of service lines shown.

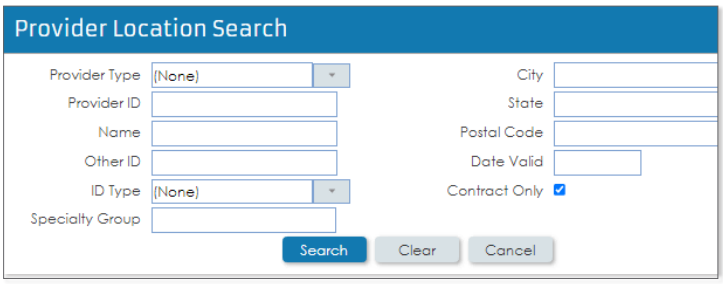


Section 2: Submit a Request *(continued)*

15. Search for the servicing provider (if different from the requesting provider). Start by clicking on the magnifying glass.

Tip: *If you don't have a servicing provider in mind, HNFS can help you locate one by typing in a specialty description in the provider specialty section.*

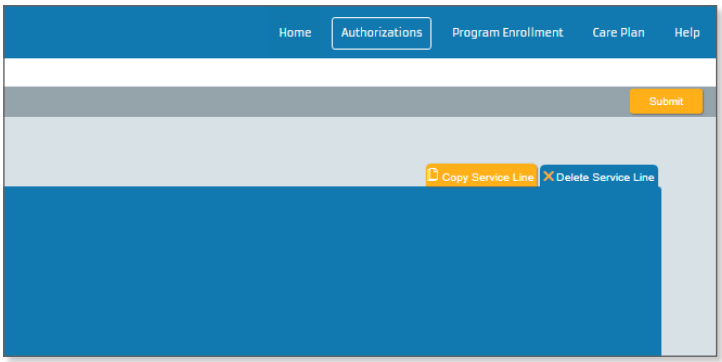
16. Use the TIN, name or other filters to narrow your search.



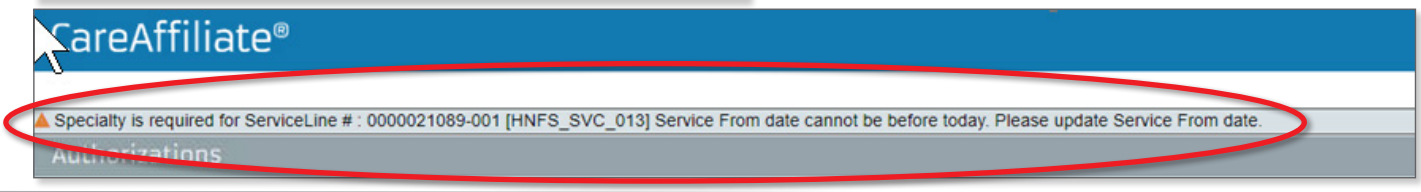
17. Enter the specialty.

Tip: *You MUST enter the servicing provider's specialty for each service line.*

18. For inpatient only.

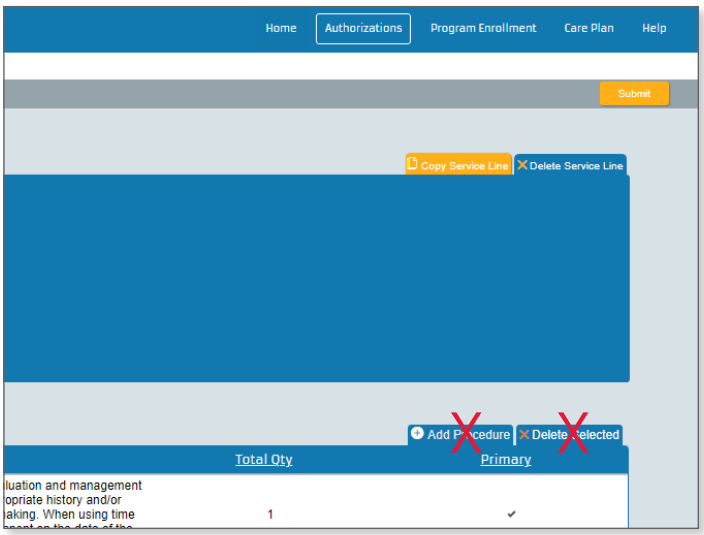


Tip: *If a provider is submitting an inpatient request with a retroactive date of service, the system will only accept it if it is entered into the "Actual Date Admitted" field. Using the "Service From" field will result in an error message.*



Section 2: Submit a Request *(continued)*

19. Repeat for additional service lines.



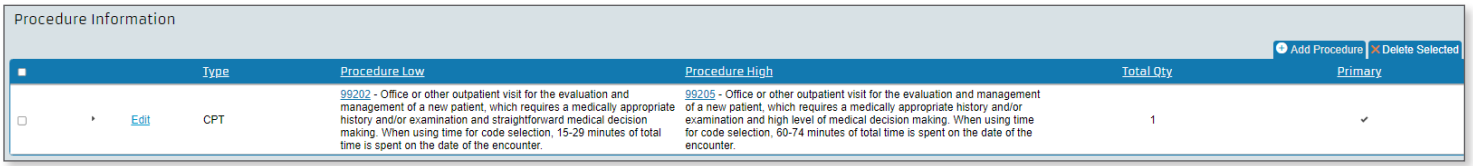
Tip: *CareAffiliate has several copy shortcut functions like* ***copy service*** *and* ***copy provider*** *when entering requests with multiple service lines. To avoid delays in processing requests, do not add a generic request type to a non-generic request type.*

Example: Office visits should be sent as a separate request from a surgical procedure. Non-generic request types are pre-populated templates specifically designed by HNFS.

20. Review the procedure codes/code ranges covered under each service line.

Keep in mind:

- The **Edit, Add Procedure** and **Delete Selected** functions cannot be used with most request types. (See *Section 3: Generic Request Types/Adding Codes*).
- The **servicing** provider will determine if additional services are needed and submit any required authorization request to HNFS ***(Tip:*** *Most diagnostic services and office procedures do not require a separate authorization).*



21. Add notes and/or attachments, if applicable.

The assessment function can be used to recommend provider demographic updates or update the beneficiary's address. *(See Section 4: Adding Notes, Attachments and Assessments)*

Note: *Requesting demographic updates using the assessment feature will only update the information for the request being submitted. Providers should use the Update Demographics tool to make permanent changes. Beneficiaries must update their record in the Defense Enrollment Eligibility Reporting System to make permanent changes.*

22. Submit your request.

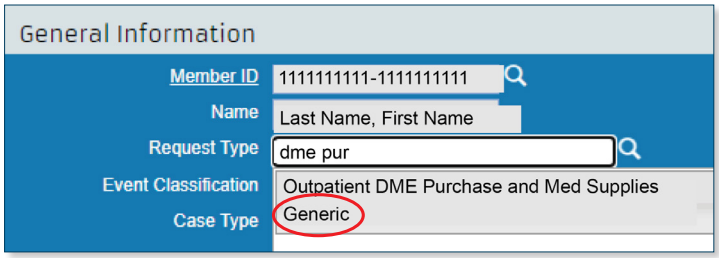
Section 3: Generic Request Types/Adding Codes

Q: ***When should I select a generic request type?***

A: You should only select a generic request type if the codes you are searching for do not fall within one of our request type templates.

Q: ***How do I know which request types are generic?***

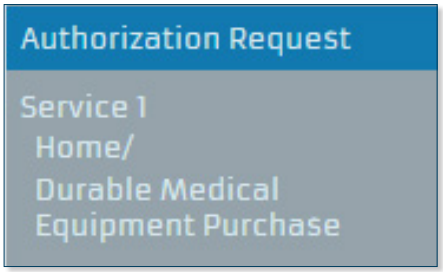
A: Generic request types generally have the word "generic" in the description. To help, we've notated all generic request types in the tables at the end of this guide with an asterisk.



CPM Machine – Knee	E0935	P54
CPM Machine – Other	E0936	P65
DME Purchase and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P108
DME Rental and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P107
Insulin Pump Purchase and Pump Supplies	E0784, A4222, A4231-A4232	P15P

Q: ***How do I add the codes I want approved to my request?***

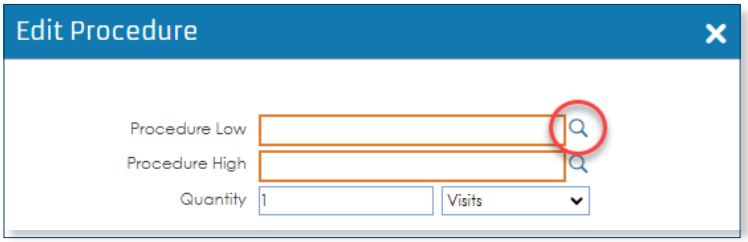
A: From the service line section, follow these steps:



1. **Select a service line from the left navigation blue section.** The request type selected determines the number and type of service lines shown.

2. **Click on Edit in the Procedure Information section.**
   Tip: *The* ***Add Procedure*** *function will remain disabled. Use the Edit function only.*

3. **Enter the code/code ranges.**
   Use the magnifying glass if you need to perform a search.



Q: ***What if I want to add codes to a non-generic request type?***

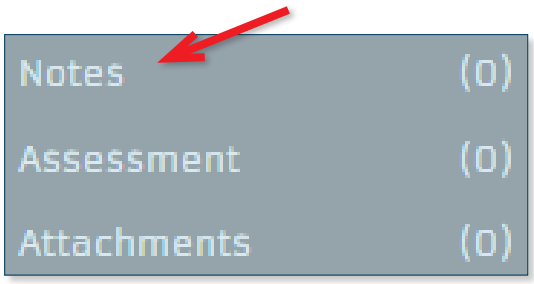
A: This function is not allowed. Remember, non-generic request types are pre-populated templates specifically designed by HNFS according to TRICARE policy.

Section 4: Notes, Assessments and Attachments

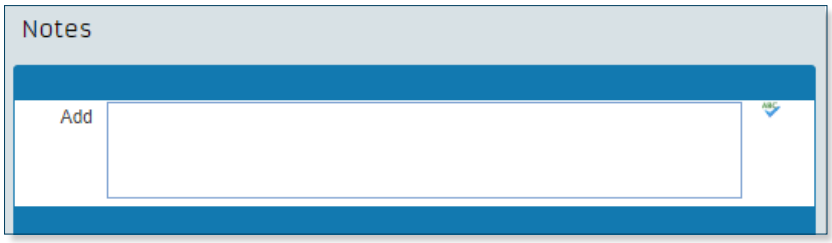
Notes

Use the **Notes** feature to provide HNFS with additional information about your request, such as clinical information in support of urgent requests.

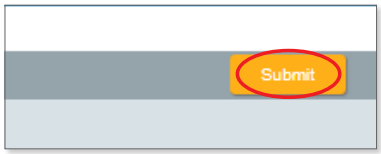
1. Click on **Notes.**



2. **Type in the Add box.** What you type in will automatically save.



3. **Only click Submit button in the upper right corner if you are done with the Notes, Assessments, Attachments section.** Once you hit the Submit button, your submission will complete.

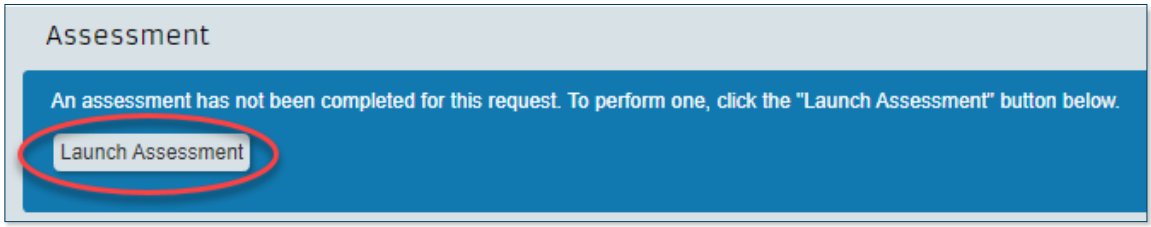


Assessments

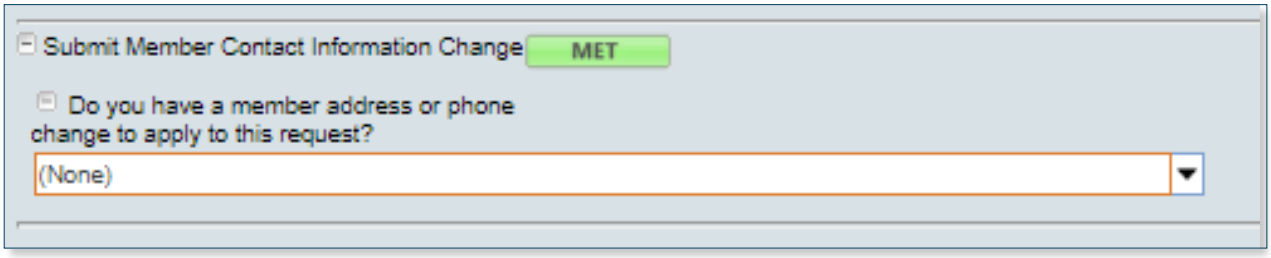
Use the **Assessment** feature to suggest patient and provider demographic updates and to supply rationale for requesting a non-network servicing provider.

1. Click on **Assessment.**

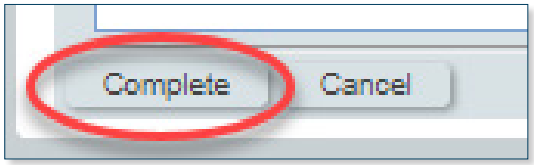
2. Click on **Launch Assessment.**



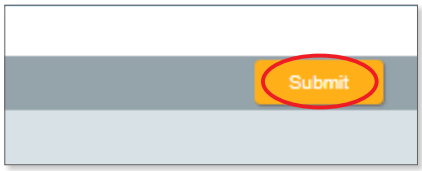
3. **Complete the appropriate fields.**
   Tip: *The* ***Assessment*** *feature also allows you to type in clinical documentation notes, but you do not need to repeat information put in the* ***Notes*** *section.*



4. **Click the Complete button.**



5. **Only click Submit button in the upper right corner if you are done with the Notes, Assessments, Attachments section.** Once you hit the Submit button, your submission will complete.

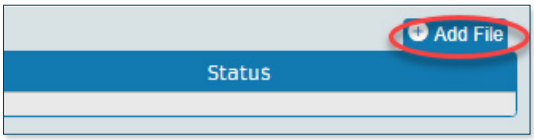


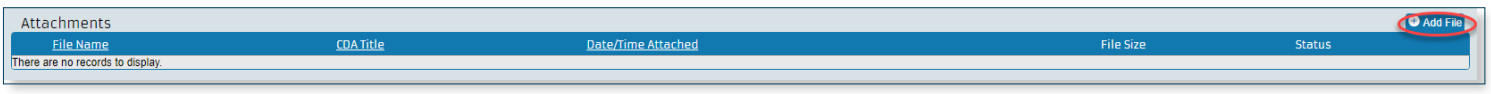
Attachments

Use the **Attachments** feature to add supporting clinical documentation, such as Letters of Attestation.

1. Click on **Attachments.**

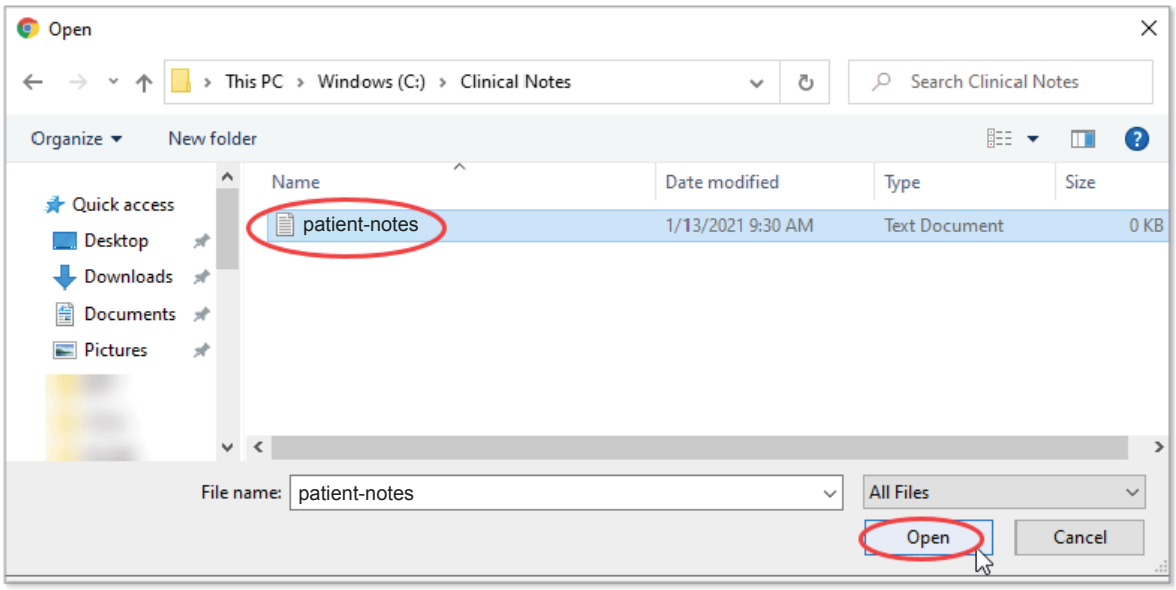
2. Click on **Add File.**



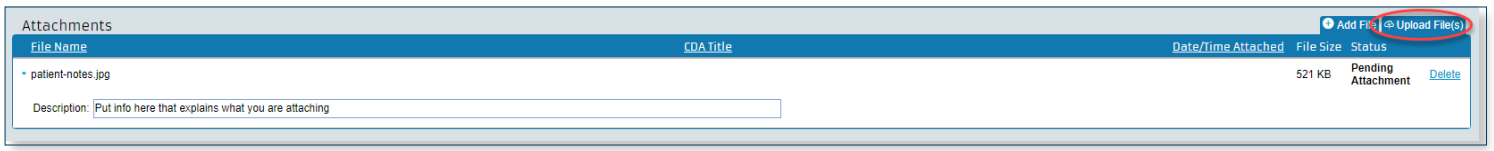


Section 4: Notes, Assessments and Attachments *(Continued)*

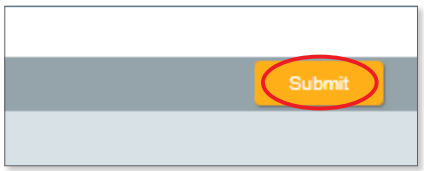
3. Navigate to the file you wish to upload.



4. Upload the file to CareAffiliate.

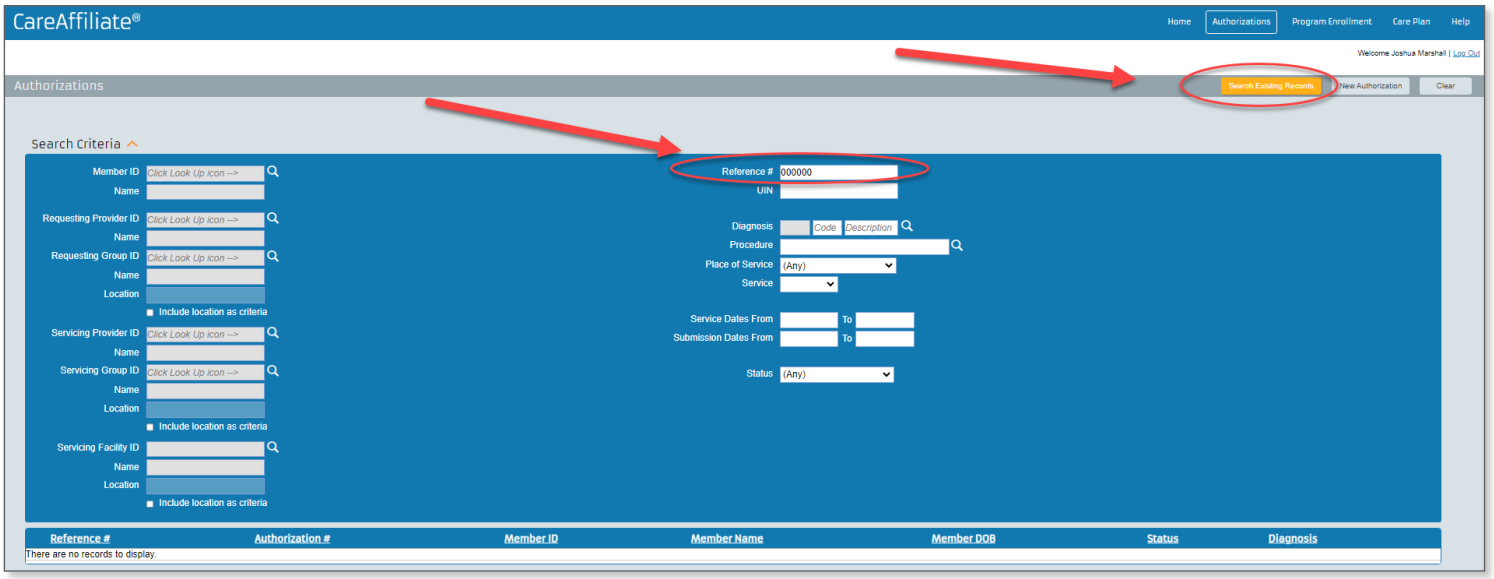


5. **Only click Submit button in the upper right corner if you are done with the Notes, Assessments, Attachments section.** Once you hit the Submit button, your submission will complete.

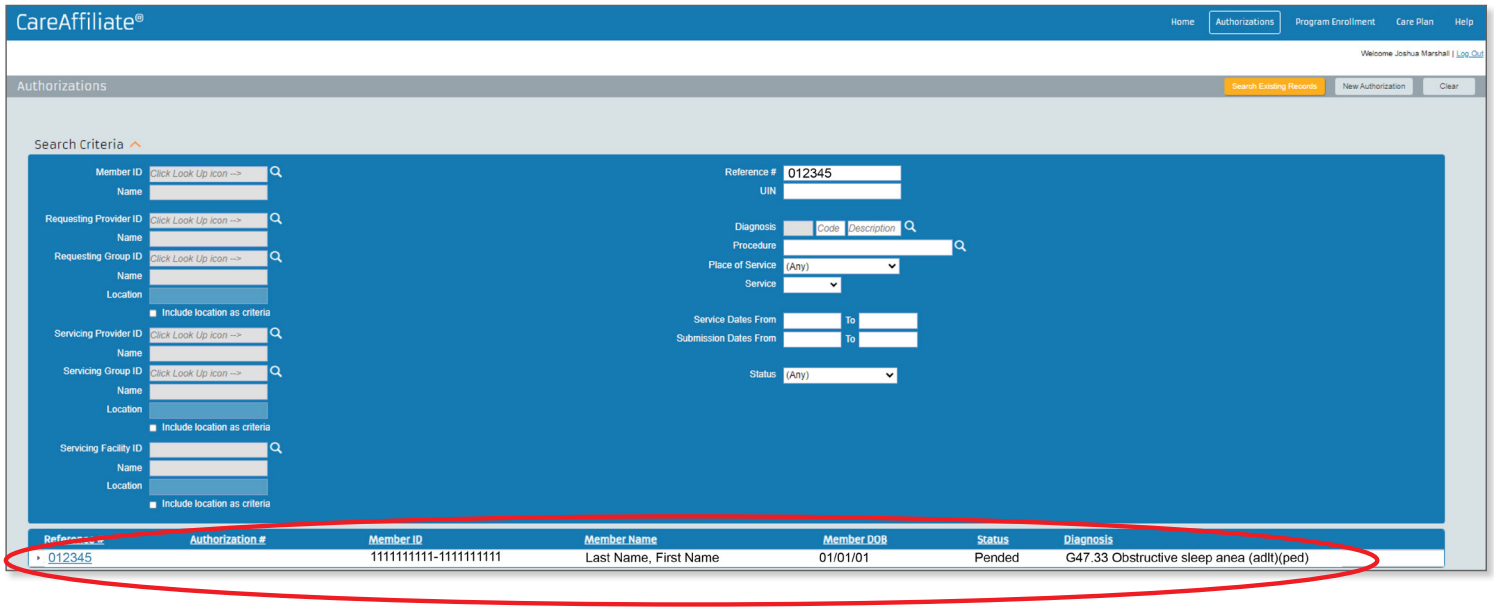


Section 5: Checking Status

1. Navigate to the **Authorizations** screen and either search by Member ID or reference number.

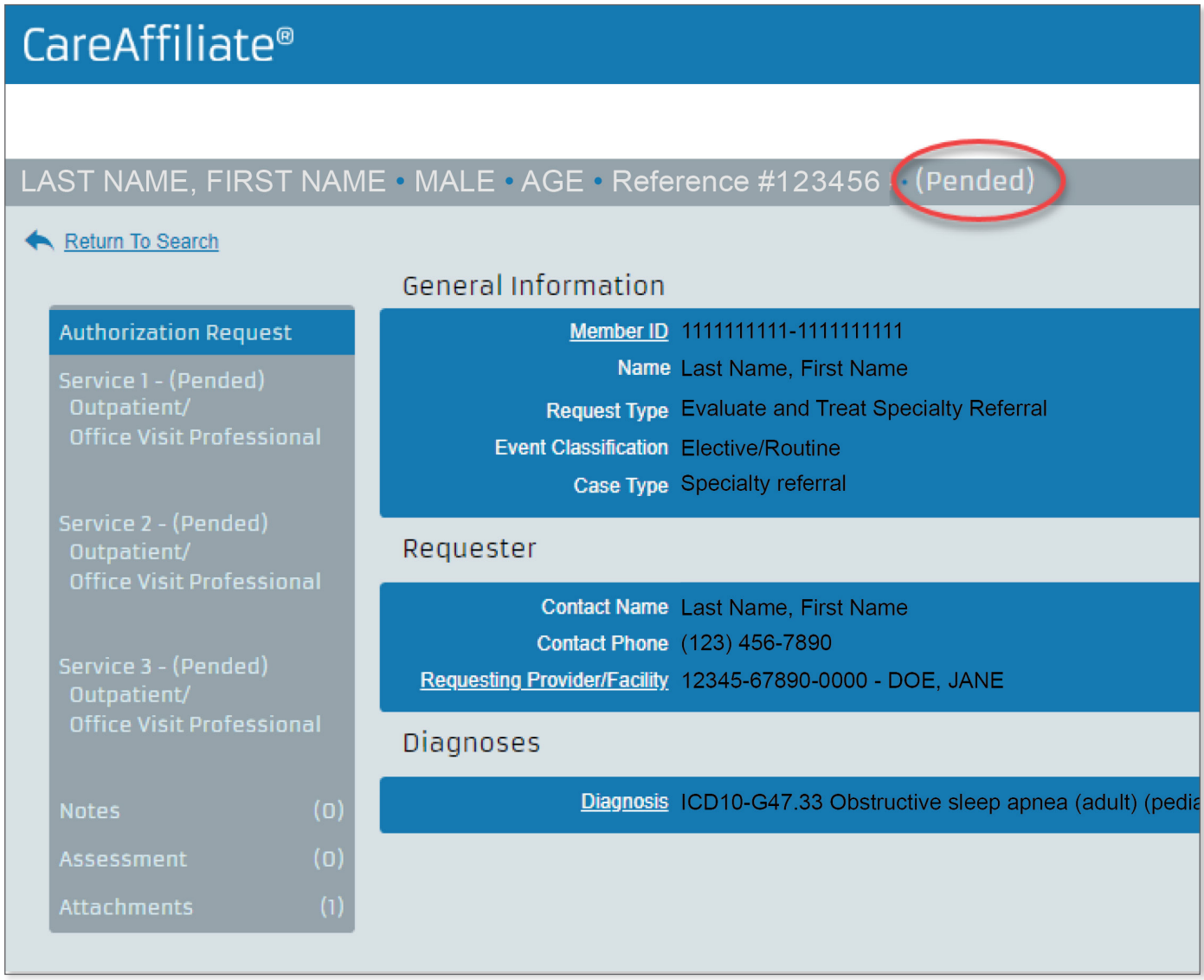


2. Select the authorization returned by the search results.



Section 5: Checking Status *(Continued)*

3. **View the authorization status.** You can monitor the status by logging in to CareAffiliate and/or print a copy of this page for your records. HNFS will notify you if additional information is needed.



Online Referral/Authorization Submissions Request Type Guide

HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE

What is a request type?

Request types are templates created for use with Health Net Federal Services, LLC's (HNFS) online referral and authorization submission tools, available at **www.tricare-west.com** > *Provider*. Each request type has been developed by HNFS in accordance with the TRICARE manuals.

When a request type is selected, the associated codes/code ranges, number of visits, and duration of the authorization will pre-populate on the request.

Table of Contents

Outpatient Specialty Referral Request Types

Description	Included CPT® Code(s)	Request Type	Approval Duration
Evaluate and Treat Specialty Referral	99202–99205, 99211–99215, 99242–99245	P1	180 days for ADSMs 365 days for non-ADSMs
Evaluate Only Specialty Referral	99202–99205, 99211–99215, 99242–99245	P3	180 days
Oncology – Evaluate and Treat Spec Ref	99202–99205, 99211–99215, 99242–99245	P6	365 days
Pre/Post Transplant	99211–99215, 99242–99245	P58	360 days for codes 90 days for codes
Routine Eye Examination	92002–92015	P63	90 days
Second Opinion	99202–99205, 99211–99215, 99242–99245	P5	90 days
Specialty Referral Extension	99211–99215	P4	180 days, dependent on initial episode of care date

ADSMs = active duty service members

Request types, descriptions and corresponding codes are subject to change.

Outpatient Authorization Request Types

Physical Health

The Approval Duration column shows HNFS' standard authorization time frames. However, if the PCM's specialty referral is still valid (see p.2 for referral durations), servicing providers should request a date extension using the online ***Authorization Change Request Form*** *rather than asking the PCM for a new referral. (Exception: For physical, speech and occupational therapy, and applied behavior analysis [ABA] and Extended Care Health Option [ECHO] services, please submit a new authorization request to HNFS.)*

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
ACD ABA Initial Assessment Authorization	97151	P174	45 days
ACD Outcome Measure Authorization	97151, 97151, 97151	P175	365 days
ACD ABA Treatment Authorization	97151, 97153, 97155, 97156, 97157, 97158, 99366, 99368	P177	180 days
ACD ABA Discharge Report Submission	99199	P178	1 day
Acupuncture	97810	P163	90 days
Adjunctive Dental*	*generic request type (enter codes manually)	P127	180 days
Air Ambulance Services	A0430–A0431	P116	14 days
Allergy Services	95004, 95017–95117	P9	180 days
Ambulance Services	A0999	P10	14 days
Audiology	92550, 92552–92557, 92563–92584, 92588	P11	90 days
Breastfeeding Counseling	99401–99404	P159	365 days
Cardiac Rehabilitation	93797–93798	P12	90 days
Chiropractic Care	98940–98943	P14	90 days
Colonoscopy	45300–45392	P43	90 days
Custodial Care Home	99600	P165	30 days
Dental Anesthesia	41899, 00170	P101	180 days
Dental/Adjunctive Dental Svc Data Entry	D9310, 992202–92205, 99242–99245	P22	180 days
Diabetic Education	G0108–G0109	P23	180 days
Diabetic Eye Exam	92082, 92250, 99203–99204	P114	90 days
Dialysis	90935	P60	90 days
Emergency Room Visit	99281–99285	P44	5 days after and 15 days prior to the date of service
Global OB	59400–59622	P76	11 months
Global OB ICD-10	59400–59622	P126	11 months
Hippotherapy	S8940	P124	180 days
Home Health Infusion Therapy*	99601–99602 *generic request type (can also enter codes manually)	P28	90 days for codes 99601–99602 180 days for all others
Home Health Basic Benefit Under PPS	0023	P26	60 days
Hospice	0651–0657, 0551, 0561, 0571	P46A	90 days
Hourly Skilled Nursing	99347	P48	90 days
Injection, Epidural (Cervical or Thoracic)	62320–62321, 77003	P30	90 days
Injection, Epidural (Lumbar or Sacral)	62322–62323, 77003	P31	90 days
Injection, Facet Joint (Cervical or Thoracic)	64490–64492	P32	90 days
Injection, Facet Joint (Lumbar or Sacral)	64493–64495	P33	90 days
Injection, HPV	90649	P29	180 days
Integrated Disability Evaluation	99456	P111	180 days
Maternity Ultrasounds	76801–76817	P34	90 days
Non-USFDA LDTs Demo*	*generic request type (enter codes manually)	P162	60 days
Nutritional Counseling	97802–97804	P24	180 days
Observation Stay	G0378–G0379	P35	10 days

Occupational Therapy – Acute Injuries	97165, 97167–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P36A	120 days
Occupational Therapy – Post Op Care	97165, 97167–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P36B	150 days
Occupational Therapy – Long Term Conditions	97165, 97167–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 7535	P36C	180 days
Opioid Replacement Therapy (ORT)	0912–0913	P152	180 days
Osteopathic Manipulation	98925–98929	P37	90 days
Outpatient Infusion Therapy or Medication Administration*	*generic request type (enter codes manually)	P115	90 days
Outpatient PH Medical Procedure*	*generic request type (enter codes manually)	P106	180 days
Outpatient PH Surgical Procedure*	*generic request type (enter codes manually)	P105	180 days
Physical and Occupational Therapy – Acute Injuries	97165–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 97161–97164, 97010, 97016-97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P125A	120 days
Physical and Occupational Therapy – Post-Op Care	97165–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 97161–97164, 97010, 97016-97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P125B	150 days
Physical and Occupational Therapy – Long-Term Conditions	97165–97168, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 97161–97164, 97010, 97016-97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P125C	180 days
Physical Therapy – Acute Injuries	97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P38A	120 days
Physical Therapy – Post-Op Care	97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852,97530, 97535	P38B	150 days
Physical Therapy – Long-Term Conditions	97161–97164, 97010, 97016–97024, 97028, 97033–97036, 97110–97124, 97140–97150, 95851–95852, 97530, 97535	P38C	180 days
Pulmonary Rehabilitation	G0237–G0238	P13	90 days
Pulmonary Rehabilitation Pre/Post Transplant	97161–97163, 97110	P59	30 days for codes 97161–97163 90 days for code 97110
Respite Care for Extended Care Health Option	99600	P47	365 days
Sleep Study	95810–95811	P40	90 days
Sleep Study (Under 6 Years Old)	95782–95783	P123	90 days
Smoking Cessation	96156, 96158–96159, 96164–96165	P62	120 days
Speech Therapy – Acute Injuries	92521–92524, 92507	P39A	120 days
Speech Therapy – Post-Op Care	92521–92524, 92507	P39B	150 days
Speech Therapy – Long-Term Conditions	92521–92524, 92507, 92610	P39C	180 days
Synagis	90378	P67	150 days
Terminal Leave Blanket Authorization	99202–99215, 90791–90792, 99202–99205	P128	This request type is to be used by military hospitals or clinics only
Trigger Point Injections	20552–20553	P41	90 days
Urgent Care	99202–99205	P45	5 days after and 15 days prior to the date of service

*= *generic request type*

Outpatient Authorization Request Types (continued)

Behavioral Health

The Approval Duration column shows HNFS' standard authorization time frames. However, if the PCM's specialty referral is still valid (see p. 2 for referral durations), servicing providers should request a date extension using the online ***Authorization Change Request Form*** *rather than asking the PCM for a new referral.*

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
Outpatient Therapy (BH)	90791–90792, 90832–90840, 90846–90853, 99211–99215, 90785, 99202–99205	P50	90 days for codes 90791–90792, 99202–99205 180 days for codes 90832–90840, 90846–90853, 99211–99215, 90785
Electroconvulsive Therapy (BH)	90791–90792, 90870	P64	90 days for codes 90791–90792 180 days for code 90870
IOP Psych (BH)	S9480	P156	90 days
IOP Substance Abuse (BH)	H0015	P157	90 days
Medication Assistant Treatment (BH)*	*generic request type (enter codes manually)	P167	180 days
Medication Management (BH)	99202–99215	P51	180 days
Observation Stay (BH)	G0379	P75	10 days
PHP Psych Full Day (BH)	0913	P71	90 days
PHP Psych Half Day (BH)	0912	P73	90 days
PHP Substance Abuse Full Day (BH)	0913	P72	90 days
PHP Substance Abuse Half Day (BH)	0912	P74	90 days
Psychological/Neuropsychological Testing (BH)	90791–90792, 96130–96146	P171	90 days for codes 90791–90792 180 days for codes 96130–96146
Sparvato® Esketamine (BH)	G2082–G2083	P173	90 days
Transcranial Magnetic Stimulation (BH)	90791–90792, 90867–90869	P166	90 days for codes 90791–90792 365 days for codes 90867–90869

*BH = behavioral health, *= generic request type*

Durable Medical Equipment Request Types

The Approval Duration column shows HNFS' standard authorization time frames. However, if the PCM referral is still valid (see p. 2 for referral durations), servicing providers may request a date extension using the online ***Authorization Change Request Form*** *rather than going back to the PCM for a new referral.*

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
ASV (Adaptive Servo-Ventilation Machine) Purchase and Supplies	E0471, E0562, A7027–A7039, A7046, A4604	P168P	455 days
ASV Rental and Supplies	E0471, E0562, A7027–A7039, A7046, A4604	P168R	455 days
BiPap Purchase and Supplies	E0562, E0470, A7030–A7039, A7046	P17P	455 days
BiPap Rental and Supplies	E0562, E0470, A7030–A7039, A7046	P17R	455 days
Breast Pump and Supplies – Heavy Duty Hospital Grade	E0604, A4281–A4286, A9999, A9900	P160	90 days for codes E0604 455 days for codes A4281-A4286, A9999, A9900
Breastfeeding Pump and Supplies	E0602–E0603, A4281–A4286, A9999, A9900	P158	455 days
Commode (3 in 1)	E0163	P57	455 days
CPAP Standard Purchase and Supplies	E0601, E0562, A7027-A7039, A7046, A4604,	P16P	455 days
CPAP Standard Rental and Supplies	E0601, E0562, A7027–A7039, A7046, A4604	P16R	455 days
CPAP Portable Purchase and Supplies	E0601, E0562, E1399, A7027–A7039, A7046, A4604	P172P	455 days
CPAP Portable Rental and Supplies	E0601, E0562, E1399, A7027–A7039, A7046, A4604	P172R	455 days
CPAP Supplies Only	A7027–A7039, A7046, A4604	P155	455 days
CPM Machine – Knee	E0935	P54	21 days
CPM Machine – Other	E0936	P65	21 days
DME Purchase and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P108	455 days
DME Rental and Med Supplies Generic (Outpatient)*	*generic request type (enter codes manually)	P107	455 days
Insulin Pump Purchase and Pump Supplies	E0784, A4222, A4231-A4232	P15P	455 days
Insulin Pump Rental and Pump Supplies	E0784, A4222, A4231-A4232	P15R	455 days
LVAD	L9900	P61	455 days
Personal Incontinence Supplies	A4520, T4521–T4536, T4539, T4543	P161	365 days
Prosthetics and Orthotics Generic (Outpatient)*	*generic request type (enter codes manually)	P109	180 days
Rolling Walker	E0143	P56	455 days
Synthetic Sheepskin Pad	E0188	P55	455 days
TENS Unit – Purchase	E0720–E0730, A4595, E0731	P113	455 days
TENS Unit – Rental	E0720–E0730, A4595, E0731	P112	455 days
Wheelchair Rental – Basic	K0001, E0990	P18	455 days
Wound Vacuum	E2402, A6550, A7000, A4221, A4222	P21	180 days

**= generic request type*

Inpatient Authorization Request Types

For use with CareAffiliate® only. The Web Authorization/Referral Form (WARF) does not support inpatient requests.

Description	Included CPT®, NDC, HCPCS Codes	Request Type	Approval Duration
Bariatric Surgery Laparoscopic Roux-en-Y (Inpatient PH)	43644	P97	30 days
Bariatric Surgery Laproscopic Banding (Inpatient PH)	43770–43774	P98	30 days
Bariatric Surgery Open Roux-en-Y (Inpatient PH)	43846	P100	30 days
Bariatric Surgery Vertical Banding (Inpatient PH)	43842	P99	30 days
BH Admit (Inpatient)	99221	P81	5 days
Chemical Dependency (BH CD) – Detoxification	99221	P83	7 days
Chemical Dependency (BH CD) – Rehabilitation	99221	P84	5 days
C-Section Delivery (Inpatient)	59514	P80	180 days
Custodial Care (Inpatient)	99324	P164	30 days
Double Lung Transplant (Inpatient PH)	32852–32584	P89	365 days
Heart Lung Transplant (Inpatient PH)	33935	P90	365 days
Heart Transplant (Inpatient PH)	33945	P94	365 days
Intestinal Transplant (Inpatient PH)	44135–44136	P93	365 days
Islet Cell Transplant (Inpatient PH)	48160	P92	365 days
Kidney Transplant (Inpatient PH)	50360, 50365, 50380	P86	355 for code 50360 365 for code 50365, 50380
Liver Transplant (Inpatient PH)	47135–47136	P87	365 days
Long Term Acute Care (Inpatient PH)	99221		30 days
Medical Admit (Inpatient PH)	99221	P77	5 days
	48554	P91	365 days
Rehabilitation – Acute (Inpatient PH)	99221	P103	30 days
Residential Treatment Center (BH Inpatient)		P82	5 days
Single Lung Transplant (Inpatient PH)	32851	P88	365 days
Skilled Care (Inpatient PH)	0022	P102	30 days
Stem Cell Transplant Allogeneic (Inpatient PH)	38240	P95	365 days
Stem Cell Transplant Autologous (Inpatient PH)	38241	P96	365 days
Surgical Admit (Inpatient PH)*	*generic request type (enter codes manually)	P78	30 days
Vaginal Delivery (Inpatient)	59409	P79	180 days

*BH = behavioral health, PH = physical health, *= generic request type*