



<b>HSCSN Request for Authorization of a Summer Program 2026</b>
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- HSCSN can cover up to one summer program per member up to a maximum cost of \$1,500.
- This is a value-added benefit offered by HSCSN. Once the budgeted amount for the benefit has been reached, new authorization requests will not be accepted. Authorization is on a first-come, first-served basis.
- The summer program must occur between Memorial Day and Labor Day 2026.
- The summer program must occur while the member is not in school.
- HSCSN will not authorize medical transportation for participation in the program.
- HSCSN will not cover personal care aide services, home health aide services, ABA services or other therapy services during the hours when the member is in the summer program.
- The summer program should be for the benefit of the member.
- The member must first be accepted by the summer program before requesting authorization.
- Authorization should be requested before (prior to) participation in the summer program.
- After authorization, payment should be requested.
- Payment for the Summer Program can be made to the caregiver to reimburse out-of-pocket expenses (through Care Navigation) or the summer program can agree to send an invoice to HSCSN for payment. Payment should be requested after authorization is approved.

This request form must be signed by a treating physician or nurse practitioner. Fax this form and supporting documents to HSCSN Utilization Management at **Fax: 202-721-7190** or email: [UM@hschealth.org](mailto:UM@hschealth.org).

**IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.**

<b>Date of Request :</b>	
<b>Member Name:</b>	<b>Member ID:</b> <span style="float: right;"><b>DOB:</b></span>
<b>Requesting Physician Name (Please Print):</b>	<b>Physician Phone #:</b> <b>Fax #:</b>
<b>Physician NPI #:</b>	<b>Physician Email:</b>
<b>Primary Diagnosis:</b>	<b>Other Diagnoses:</b>
<b>Name of Summer Program:</b>	
<b>Organization:</b>	
<b>Contact Person:</b>	<b>Phone #:</b>
<b>Email:</b>	
<b>Dates for Authorization</b>	<b>Start Date:</b> <span style="float: right;"><b>End Date:</b></span>
<b>Cost: \$</b>	<b>Payment Options:</b> <input type="checkbox"/> Reimbursement of Caregiver <input type="checkbox"/> Payment of Provider Invoice



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**I. A Description of the Summer Program must be submitted with the request.**

**Summer Program Description attached:**  Yes     No, explain:

**II. Practitioner Attestation:** I am an active treating provider for the above patient and have discussed participation in the above Summer Program with the caregiver. It is my medical opinion that the Summer Program above is appropriate for the patient, there are no medical contraindications, and I will sign any orders necessary for the patient to participate in the program.

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name/Credentials:** \_\_\_\_\_