



Health Plan
Medicare *Advantage* Plans
Health Plan Commercial Groups

IMPORTANT: Please complete the prior authorization request form attached completely and accurately to prevent processing delays.

Expedited Review: A clinical reason must be stated. Urgent Review is completed within 72 hours of receipt of the request. Scheduling concerns do not meet expedited review criteria.

DME: Billed amounts of \$500 or less DO NOT REQUIRE PRIOR AUTHORIZATION. Please include the billed amount in the notes section of the attached form. Your request WILL NOT be processed without this information.

Medical Pharmacy: Injectables/Infusion/Biologicals. Billed amounts of \$1000 or less DO NOT REQUIRE PRIOR AUTHORIZATION. Please include the billed amount in the notes section of the attached form. Your request WILL NOT be processed without this information.



Standard

Expedited: The referring provider believes that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

BH Inpatient Services	Chemical Dependency	RTC
Intensive Outpatient Therapy	Partial Hospitalization (PHP)	Other
		Scheduled Date: _____
*Authorization is recommended prior to scheduling services		

<u>Requestor Information</u>		<u>Member Information</u>	
Requester Name & Phone:		Member Name:	
Ordering Physician Name:		Member ID Number:	
Ordering Physician NPI:		Member DOB:	
Phone Number:			
Fax Number:			
<u>Servicing Provider Information</u>		<u>Facility Information</u>	
Servicing Provider Name:		Facility Name:	
NPI Number:		NPI Number:	
Tax Identification Number:		Tax Identification Number:	
Specialty:		Street Address:	
Street Address:		City and State:	
City, State, and Zip Code:		Zip Code:	
Phone and Fax Number:		Phone and Fax Number:	
Is this provider In Network? (Y/N) _____		Is this provider In Network? (Y/N) _____	
<u>Procedure Codes (Please include Units)</u>		<u>Diagnosis Codes</u>	
CPT/HCPC Code(s):	Units:	ICD-10 Code(s):	
CPT/HCPC Code(s):	Units:	ICD-10 Code(s):	
CPT/HCPC Code(s):	Units:	ICD-10 Code(s):	
Service Dates: From	To:		
Space for Additional Codes:			
<u>Space for Medical Note(s) Below</u>			
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***Supporting clinical Information must contain legible documentation that is applicable, i.e. symptoms, illness duration, pertinent test(s), and treatment. A legitimate clinical reason must be provided and meet criteria for expedited processing. Scheduling concerns does not meet expedited review criteria.**

Fax this form with clinical to 281-823-7355