Medicare Advantage Prior Authorization Request Form

Instructions: Please fill out all applicable sections on both pages completely and legibly before faxing or mailing the form to the number or address listed below. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. Information contained in this form is Protected Health Information under HIPAA.

Please Note: Preservice organization determination requests aren't needed for services that don't require prior authorization. However, we recommend them for procedures or services that may be considered cosmetic, investigational or not a covered benefit. This makes sure services meet medical criteria/guidelines and take the place of any authorization requirements. Failure to obtain any necessary authorizations may result in a denial or reduction in benefits.

1. Prior authorization priority

☐ **a. Standard Requests - Fax: 816-313-3014** Elective admission or services to be scheduled within 30 days (prior authorization date ranges may vary).	☐ **b. Expedited Requests - Fax: 816-313-3013** Provider certifies that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to recover, or result in serious impairment or permanent disability. Requests sent as expedited that do not meet the above criteria will be changed to a standard request.

2. Prior authorization type

☐ **a. Preservice** ☐ **b. Extension** ☐ **c. Out of Network** Previous authorization #:

3. Patient information

First name	**Middle initial** (M.I.)	**Last name**

Phone number	**Patient DOB** (mm/dd/yyyy)	**Member ID #** (including prefix)

Patient address	**City**	**State**	**ZIP**

4. Ordering provider

Provider name	**Tax ID #**	**NPI #**	**Specialty**	**Contact name**

Group name	**Phone**	**Fax**

Group address	**City**	**State**	**ZIP**

Email	**DEA #** (if applicable)

5. Servicing specialist/Clinic/Facility provider (will provide requested service/medication/device)

Specialist name	Tax ID #	NPI #	Specialty	Contact name

Is servicing provider in-network for this member's benefit plan?

☐ Yes ☐ No

Group/Facility name	Phone	Fax

Group address	City	State	ZIP

Email	DEA # (if applicable)

6. Medical service/Procedure/Course of treatment/Device information

Please indicate specifics about place and type of service

Places of service

☐ Office ☐ Outpatient ☐ Inpatient ☐ Home ☐ *Other

*Please specify if other:

Types of service (check applicable boxes)

- ☐ Trials
- ☐ Dental services
- ☐ Diagnostic testing/ monitoring
- ☐ DME
- ☐ Extended rehab (EAR)
- ☐ Fertility services
- ☐ Genetic testing
- ☐ HIV screening
- ☐ Home health
- ☐ Hospice
- ☐ Infusion/IV Therapy
- ☐ Injectable medications
- ☐ Inpat admissions
- ☐ LTAC
- ☐ Medical oncology
- ☐ OT (cognitive skills)
- ☐ Out-of-network provider
- ☐ Outpatient surgery
- ☐ Radiation therapy
- ☐ Radiology (high-tech imaging)
- ☐ SNF
- ☐ Sleep studies
- ☐ ST (swallowing studies, spoken language comprehension)
- ☐ Transplants

7. Coding

ICD-10 code(s)	ICD-10 description

HCPCS/CPT/CDT code	Code description	Medical reason	Start date	End date	Frequency requested

Other Clinical Information: Include/attach clinical/office notes, laboratory information, imaging reports, and any other necessary information to support medical necessity. If this is a request for out-of-network services, please provide an explanation.

8. Other services (Requiring prior authorization)

Type of service	Name of therapy/agency	Units/Visits requested

Frequency/Length of time needed	Precertification type ☐ Initial ☐ Extension	Previous precertification #

Additional comments

9. Previous services/therapy (Including medication, dose, duration)

a.	**Date** (mm/dd/yyyy)
b.	**Date** (mm/dd/yyyy)
c.	**Date** (mm/dd/yyyy)
d. Reason for discontinuing previous therapy (e.g. contraindications, allergies, therapeutic failure)	

Additional Information: Please attach and submit any progress notes, lab data, discharge summaries, or other relevant documentation to support discontinuation of previous therapy.

10. Previous services/therapy (Including medication, dose, duration)

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Requester signature

Date signed (mm/dd/yyyy)

Please return this signed form to:
Arkansas Blue Medicare
ATTN: 10th Fl MA Utilization Management
320 W Capitol
Little Rock, AR 72202

or

Fax:
Standard Requests: 816-313-3014
Expedited Requests: 816-313-3013

For office use only

(do not write in this space)

Authorization #	**Contact name**
Contact's credentials/designation	