



CONFIDENTIAL – MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

OUTPATIENT REQUEST

Required Information: To ensure our patients receive quality and timely care, please complete this form in its entirety and submit with appropriate supporting clinical documentation (i.e., H&P, imaging reports, surgical reports, and other pertinent medical info).

DATE OF REQUEST

Fax: 1-888-972-2082
Phone: 1-866-390-0973

REVIEW PRIORITY LEVEL
Service requested can be reviewed within standard timelines. Standard review completed within 14 calendar days.
The health or life of member may seriously be jeopardized if the service requested is not reviewed expeditiously. Expedited review completed within 72 hours.

MEMBER INFORMATION
Member ID: Last Name:
Medicare #: First Name: Middle Initial:
Date of Birth: Phone #: () -

REQUESTING PROVIDER INFORMATION
NPI # / Tax ID: Provider Last Name: First Name:
Street Address:
Provider Type / Specialty: City: State: ZIP Code:
Phone #: () - Fax #: () -

SERVICING PROVIDER INFORMATION
Out of Network Provider (Give reason for requesting in the space below.)
NPI # / Tax ID: Provider Last Name: First Name:
Street Address:
Provider Type / Specialty: City: State: ZIP Code:
Phone #: () - Fax #: () -

TYPE OF OUTPATIENT SERVICE
Ambulatory Surgery Home Health Services Hospital Services
Lab Services Office Visits / Procedures Therapy Services

SERVICING FACILITY INFORMATION
Facility Type: Office Outpatient Hospital Ambulatory Surgical Center Free Standing
Out of Network (Give reason for requesting in the space below.)
NPI # / Tax ID: Facility Name:
Street Address:
City: State: ZIP Code:
Phone #: () - Fax #: () -

SERVICES REQUESTED
Start Date of Service: Phone #: () -
Primary ICD-10 Code: Code Description:
Secondary ICD-10 Code: Code Description:
CPT / HCPC Codes Units / Visits Frequency

Authorization is not a guarantee of claim payment. The payment for these services is subject to using the authorized provider, your plan eligibility at the time of service, and the benefit limitations in your Evidence of Coverage.

Additional Instructions
Prior Authorization Request for Outpatient Services

Please note that a traditional cover sheet may also be utilized as the first page of the fax as long as the completed prior authorization form is included as the second page in the transmission:

1st Page
Your fax
cover sheet

2nd Page
Prior Authorization
Request Form

3rd Page
Supporting Clinical
Documents

Remember to provide the required information to ensure our members receive quality and timely care.

This includes, but not limited to, completing this form in its entirety and submitting with appropriate supporting clinical documentation (i.e., H&P, imaging reports, surgical reports, and other pertinent admission records).

After the fax is received by Bright Health, you will be contacted at the requesting phone number if there are any outstanding questions or concerns.

Confirmations for approved authorizations will be faxed to the requesting provider fax number.

Definition for Priority Level:

- **Standard request:** Bright Health must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date Bright Health receives the request.
- **Expedited request:** Member or any physician (regardless of whether the physician is affiliated with Bright Health), may request that Bright Health expedite the request when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

If you have any questions regarding this form and/or request, please contact provider services:

1-844-201-0677

8:00 a.m. – 6:00 p.m., local time

Monday – Friday, excluding federal holidays

Your Bright Health Team

Fax - Confidential

To:

Bright Health Plan

From:

Fax:

1-888-972-2082

Date:

Phone:

Re:

Outpatient Prior Authorization Request

Additional Message