bright HEALTH

CONFIDENTIAL – MEDICARE ADVANTAGE

PRIOR AUTHORIZATION REQUEST FORM

INPATIENT 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	Pre-Cert Approval #

Fax: 1-888-972-2081
Phone: 1-866-406-8027

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:		

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 #:**	

ADMISSION TYPE - FACILITY

☐ Inpatient	☐ Inpatient Rehab	☐ Hospice
☐ LTACH	☐ Observation	☐ Skilled Nursing

SERVICING FACILITY INFORMATION

☐ **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 Inpatient 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	**2nd Page**	**3rd Page**
Your fax cover sheet	Prior Authorization Request Form	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:

1-844-201-4027
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: 1-888-972-2081	**Date:**
	Phone:
Re: Inpatient Prior Authorization Request	

Additional Message