bright HEALTH

CONFIDENTIAL - MEDICARE ADVANTAGE

PRIOR AUTHORIZATION REQUEST FORM

SUBSTANCE USE DISORDER 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.

DATE OF REQUEST

Fax: 1-888-972-2076

Phone: 1-877-874-7201

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:**	
Date of Birth:	**First Name:**	**Middle Initial:**

REQUESTING PROVIDER INFORMATION

Provider Network Status:	☐ **In Network Provider**	☐ **Out of Network Provider**	
Provider Service Location:	☐ **In Network Facility**	☐ **Out of Network Facility**	
NPI # / Tax ID:	**Provider Last Name:**	**First Name:**	
	Street Address:		
Facility/ Clinic/ Provider:	**City:**	**State:**	**ZIP Code:**
	Phone #: ( ) -	**Fax #:** ( ) -	

LEVEL OF CARE REQUESTED

☐ Inpatient Detoxification

☐ Inpatient Rehabilitation (Short Term is 1-14 days.)

☐ Intensive Outpatient Program (IOP)

☐ Outpatient Treatment (List all applicable billing codes below.)

☐ Partial Hospitalization Program (PHP)

☐ Residential Treatment (Long Term is 14+ days.)

☐ Other (please list):

SERVICES REQUESTED

Start Date of Service (MM/DD/YYYY)**:**

Estimated Duration of this Episode of Care:

CPT / HCPC Codes	Units / Visits	Frequency

DIAGNOSIS

(If additional rows for diagnoses are required, include those additions as attachments to this page for supporting documentation.)

1.

2.

3.

4.

MEDICATION(S)

☐ Medications Not Applicable

Name	Dosage	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 Substance Use Disorder 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:

1-844-201-1912
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: 1-888-972-2076	**Date:**
	Phone:
Re: Substance Use Disorder Prior Authorization Request	

Additional Message