



**CONFIDENTIAL – MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

**BEHAVIORAL  
HEALTH  
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:** 1-877-874-7241

**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**

<b>Member ID:</b>	<b>Last Name:</b>
<b>Date of Birth:</b>	<b>First Name:</b> <b>Middle Initial:</b>

**REQUESTING PROVIDER INFORMATION**

<b>Provider Network Status:</b>	<input type="checkbox"/> In Network Provider	<input type="checkbox"/> Out of Network Provider
<b>Provider Service Location:</b>	<input type="checkbox"/> In Network Facility	<input type="checkbox"/> Out of Network Facility
<b>NPI # / Tax ID:</b>	<b>Provider Last Name:</b>	<b>First Name:</b>
<b>Street Address:</b>		
<b>Facility/ Clinic/ Provider:</b>	<b>City:</b>	<b>State:</b> <b>ZIP Code:</b>
<b>Phone #: ( ) -</b>		<b>Fax #: ( ) -</b>

**LEVEL OF CARE REQUESTED**

- Inpatient Hospitalization
- Residential Treatment
- Partial Hospitalization (PHP)
- Structured Intensive Outpatient (IOP)
- Outpatient Treatment (List all applicable billing codes in the space below.)

**SERVICES REQUESTED**

<b>Start Date of Service:</b>		
<b>Estimated Duration of this Episode of Care:</b>		
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)**

<input type="checkbox"/> 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 Behavioral Health 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:

#### 1<sup>st</sup> Page

Your fax  
cover sheet

#### 2<sup>nd</sup> Page

Prior Authorization  
Request Form

#### 3<sup>rd</sup> 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:

**1-844-202-4125**

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:**

Behavioral Health Prior Authorization Request

## Additional Message