CONFIDENTIAL – INDIVIDUAL & FAMILY PLAN

OUTPATIENT PRIOR AUTHORIZATION REQUEST FORM

Fax: 1-833-381-6596
Phone: 1-844-808-1251

DATE OF 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.)

TYPE OF SERVICE REQUEST

☐ Service requested can be *reviewed within standard timelines*. Standard review completed within 15 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

First Name:	**Last Name:**
Member ID: 1 | | | | | | | |	**Date of Birth:**
Phone Number:	

OUTPATIENT SERVICE BEING REQUESTED: *(please select)*

☐ Ambulatory Surgery	☐ Home Care & Home Infusion	☐ 2nd Opinion, MD/office ONLY
☐ Hospital Services	☐ Office/Clinic Visits	☐ Lab/Diagnostic Testing
Durable Medical Equipment (DME); DME Providers: Apria, Homelink, Lincare. ☐ Need for DME at discharge - *NOTICE of limited 7-day coverage. After 7-day grace period, PA reviewed for medical necessity.* ☐ Standard/Routine - *Request for DME*		☐ Other:

Anticipated Date(s) of Service:

Diagnosis Code(s):

Requested Services & CPT Codes:

REQUESTING PROVIDER INFORMATION

Name:		**Provider NPI:**
Address:		
Phone:	**Fax:**	**Provider TIN:**

SERVICING PROVIDER INFORMATION

Name:		**Provider NPI:**
Address:		
Phone:	**Fax:**	**Provider TIN:**

SERVICING FACILITY INFORMATION

Name:		**Facility NPI:**
Address:		
Phone:	**Fax:**	**Facility TIN:**

ADDITIONAL INSTRUCTIONS FOR SUBMITTING PRIOR AUTHORIZATION (PA)
This PA Request form is NOT intended for Bright Health's Medicare Advantage ("MA") plans. Please visit Availity.com or BrightHealthPlan.com for authorization request information related to MA products.

STEP 1: Complete your fax cover sheet (included on next page)
STEP 2: Complete your Individual & Family Plan Prior Authorization Request Form (Page 1, above)
STEP 3: Include all necessary supporting clinical documentation

After Bright Health receives your prior authorization request, you will be contacted at the requesting phone number if there are any outstanding questions or concerns.

Prior Authorization Processing Time

1. **Standard/Routine Request:** Bright Health must notify the member of its determination as expeditiously as possible, but no later than 15 calendar days after the date Bright Health receives the request.

2. **Expedited Request:** Submission of an expedited request is appropriate when a standard determination turnaround time frame could seriously jeopardize the life or health of a member. A member must be notified of the determination no later than 72 hours after the date Bright Health receives the request.

For faster processing, please include all pertinent clinical documentation to substantiate medical necessity of the requested service. Details and documentation may include:

- ☐ Reason the study is being requested (e.g., further evaluation, rule out a disorder)
- ☐ Symptoms and their duration
- ☐ Physical exam findings and progress notes
- ☐ Initial or follow up screening (if follow up, include outcome of previous screening and date)
- ☐ Conservative treatment (and its attempted duration) patient has already completed (e.g., physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications)
- ☐ Preliminary procedures already completed (e.g., x-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation)
- ☐ Items/services are related to a confirmed rare disease diagnosis per NIH/National standards.

3. **For any preventive screening tests/services**
   a. If initial age appropriate screening, note this on PA Form.
   b. If follow up age appropriate screening, note this on PA Form and include date of previous screenings and result of the screenings.
   c. If member under age for recommended screening, submit clinical information stating initial or follow up screening and why it is needed. Also include results/date of previous screenings.

Physician Signature **Date**

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.

Fax - Confidential

To: Bright Health Plan	**From:**
Fax: 1-833-381-6596	**Date:**
Phone:	
Re:	

Additional Message: