Confidential – Individual & Family Plan

Substance Use Disorder Prior Authorization Request

bright HEALTH

DATE OF REQUEST: _____ **Fax:** 1-833-903-1067 | **Phone:** 1-844-990-0375

Required Information: To ensure our members 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.**
☐ The health or life of member **may seriously be jeopardized** if the service requested is not reviewed expeditiously.

Member Information	
Member ID: (9-digit#, begins with 1)	
First Name:	Last Name:
Date of Birth:	Phone Number:

Requesting Provider Information			
NPI #:	Last Name:	First Name:	
Tax ID #:	Street Address:		
Provider Type/Specialty:	City:	State:	Zip:
	Phone:	Fax:	

Servicing Provider Information			
NPI #:	Last Name:	First Name:	
Tax ID #:	Street Address:		
Provider Type/Specialty:	City:	State:	Zip:
	Phone:	Fax:	

Servicing Facility Information			
NPI #:	Facility Name:		
Tax ID #:	Street Address:		
Facility Type:	City:	State:	Zip:
	Phone:	Fax:	

Level of Care Requested		
☐ Inpatient Detoxification	☐ Inpatient Rehabilitation (Short Term 1-14 days)	☐ Intensive Outpatient Program (IOP)
☐ Outpatient Treatment (List all applicable billing codes below)	☐ Partial Hospitalization Program (PHP)	☐ Residential Treatment (Long Term 14+ days)
☐ Other (please list):		

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 Certificate of Coverage.

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.

Medication(s)
☐ Medications not applicable.

Name	Dosage	Frequency

Additional Instructions

Substance Use Disorder Prior Authorization Request Form

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 Substance Use Disorder Prior Authorization Request Form.

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 questions.

Prior Authorization Processing Time

Utilization Review Timelines				
Category	**Standard**	**Urgent**	**Concurrent**	**Retrospective**
URAC Standard	15 calendar days	72 hours	24 hours	30 calendar days
States following URAC: Alabama, Arizona, Ohio, Tennessee, Florida, Nebraska, Oklahoma				
Unique State Requirements				
North Carolina	3 business days			30 calendar days
Colorado*	5 calendar days	Less of 2 business days/72 hours	24 hours	30 calendar days
South Carolina	2 business days		1 business day	2 business days

**2020 IFP Statute Change*

Turn around times apply so long as complete documentation is submitted with the prior authorization request in order to make a determination.

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, referrals to specialist)
- Items/services are related to a confirmed rare disease diagnosis per NIH/National standards.

Note: Prior authorizations can be submitted electronically when requesting and servicing provider and/or facility is a contracted network provider or facility with Bright Health. Visit Bright Health's Provider Portal, Availity.com.

Benefits of submitting PA forms electronically:

1. Providers **receive immediate confirmation** that a request was submitted successfully.
2. Providers **receive a reference number** for each prior-authorization submitted.
3. Providers **can view the current status** of a submitted prior-authorization at any time

For any preventive screening tests/services

1. If **initial** age appropriate screening, note this on PA Form.
2. If **follow-up** age appropriate screening, note this on PA Form and include date of previous screenings and result of the screenings.
3. 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.

If you have any questions regarding this form and/or would like more information about Bright Health's Utilization Management program, please review our Provider Manual on the Provider Portal, Availity.com.

Fax – Confidential

To: Bright Health Plan	**From:**
Fax: 1-833-903-1067	**Date:**
Phone:	
Re: Substance Use Disorder Prior Authorization Request	
Additional Message:	