

Outpatient Prior Authorization Request Form

Date of Request: _____ **Fax:** 1-833-903-1067 | **Phone:** 1-844-929-0162

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.

Review Priority Level			
<input type="checkbox"/> Service requested can be reviewed within standard timelines . Standard review completed within 14 calendar days.			
<input type="checkbox"/> 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: (9-digit#, begins with 5):		Date of Birth:	Phone:
Last Name:		First Name:	MI:
Requesting Provider Information			
NPI #:		Requesting Provider Name:	
Tax ID #:		Street Address:	
Provider Type/Specialty:	City:	State:	Zip:
	Phone:		Fax:
Servicing Provider Information			
NPI #:		Servicing Provider Name:	
Tax ID #:		Street Address:	
Provider Type/Specialty:	City:	State:	Zip:
	Phone:		Fax:
Servicing Facility Information			
Facility Type: <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Free Standing			
NPI #:		Servicing Facility Name:	
Tax ID #:		Street Address:	
		City:	State: Zip:
		Phone:	
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 Outpatient Services

Please note that a traditional cover sheet may also be utilized as the first page of the fax as long as the completed and printed authorization form is included as the second page in the transmission:

1st Page Your fax cover sheet	2nd Page Printed Authorization Request Form	3rd Page Supporting Clinical Documents
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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 or 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.

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. The authorization submission process is streamlined by the type of authorization request. This **reduces back and forth between provider and payer**.
3. Providers **receive a reference number** for each prior-authorization submitted. Providers can **view the current status** of a submitted prior-authorization at any time.

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: Outpatient Prior Authorization Request	
Additional Message:	