Medicare Advantage Prior Authorization Form

Bright HealthCare

Phone: 1-844-926-4522
Fax: 1-888-337-2174

Requestor's Contact Name:	Requestor's Contact #:
Patient Information:	
*Name:	*DOB:
*Member ID #:	*Member Phone #:
*Service Is: ☐ New Request	☐ Extension to Authorization #
*Priority Is: ☐ Standard (Elective/Routine)	☐ Expedited/Urgent - request is to prevent serious determination in health or Jeopardize member's ability to regain maximum function.

***Service Type Requested:** Please review plans benefit prior to request

Inpatient	Outpatient	Behavioral Health	Other
☐ Emergent Inpatient	☐ Acupuncture	☐ Inpatient	☐ Cochlear Implants/Hearing Aids
☐ Concurrent Review	☐ Cosmetic	☐ Partial Hospitalization	☐ Dental Anesthesia
☐ Surgical Procedures	☐ Elective Procedure	☐ Intensive Outpatient (IOP)	☐ Durable Medical Equipment
☐ Elective Admission	☐ Advanced Imaging	☐ Residential Treatment	☐ Diagnostic Service
☐ Elective Observation	☐ MRI/MRA	☐ Substance Abuse Disorder	☐ Injectable Medications
☐ SNF	☐ CT/PET Scan	☐ ABA Services	☐ Infertility Services
☐ Rehab	☐ Sleep Study	☐ Other:	☐ Transportation
☐ Maternity	☐ Podiatry Services		☐ Vision Services
☐ Transplant	☐ Pain Management		☐ Other:
	☐ Transplant Workup		

Procedure Information:

***Service Start Date:** **Service End Date:**

ICD 10 Diagnosis Code(s)	CPT/HCPCs/Rev Code(s)	Quantity	Requested Type (Units Visits, Days, Hours)	Frequency (Example: 2x/week)

Provider Information:

Ordering Provider	Is this the member's Primary Care Physician? ☐ Yes ☐ No	
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Servicing Provider	Is this the same as the Ordering Provider? ☐ Yes ☐ No	
*Name	*NPI:	*TIN:
*Phone	*Fax:	
*Address		
Facility		
*Name:	*NPI:	*TIN:
*Phone	*Fax	
*Address		

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Always verify eligibility, benefits, and prior authorization requirements

For Claim Denial or Prior Authorization Denial, submit an Appeal through Customer Service at 1-844-926-4522