

OKLAHOMA AUTHORIZATION REQUEST FORM

CONFIDENTIAL— INDIVIDUAL & FAMILY PLAN or SMALL GROUP



BEHAVIORAL HEALTH Outpatient Prior Authorization Request Form

DATE OF REQUEST: _____

Fax: 888-319-6479

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.)

Please submit requests for prior authorizations before rendering services when applicable.

| <input type="checkbox"/> 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: _____ | | | |
| Address: _____ | | | | | | |
| Behavioral Health Service Being Requested (please select) | | | | | | |
| <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> ECT <input type="checkbox"/> Intensive Outpatient Program (IOP) <input type="checkbox"/> Outpatient Treatment (list applicable billing codes below) <input type="checkbox"/> Partial Hospitalization Program (PHP) <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Transcranial Magnetic Stimulation <input type="checkbox"/> Other: _____ | | | | Medication(s): If applicable, list name, dosage, frequency. _____ _____ _____ | | |
| Is request associated with a clinical trial? <input type="checkbox"/> Yes or <input type="checkbox"/> No If Yes, enter NCT # _____ | | | | | | |
| Diagnosis (ICD -10) Code(s): _____ | | | | | | |
| Place of Service (e.g., Office): _____ | | | | | | |
| CPT/HCPC/REV Code(s) | Total Qty | Unit Type (Units/Day, etc.) | Number | Frequency (Hour/Day, etc.) | From Date (mm/dd/yyyy) | To Date (mm/dd/yyyy) |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Requesting Provider Information (Cannot be a practice) | | | | | | |
| NPI #: _____ | | Requesting Provider Name: _____ | | | | |
| Tax ID #: _____ | | Street Address: _____ | | | | |
| Provider Type/Specialty: _____ | | City: _____ | | State: _____ | | Zip: _____ |
| Phone: _____ | | | Fax: _____ | | | |

| Servicing Provider Information (Cannot be a practice) | | | |
|---|--------|--------------------------|------|
| NPI #: | | Servicing Provider Name: | |
| Tax ID #: | | Street Address: | |
| Provider Type/Specialty: | City: | State: | Zip: |
| | Phone: | Fax: | |
| Servicing Facility/Practice Information | | | |
| NPI #: | | Facility Name: | |
| Tax ID #: | | Street Address: | |
| Facility Type: | City: | State: | Zip: |
| | Phone: | Fax: | |
| Reimbursement contact (required): | Phone: | Email: | Fax: |

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.**

Incomplete documentation of the TIN for the servicing provider and/or facility/practice may require additional information to be requested in order for payment to claim to be completed.

ADDITIONAL INSTRUCTIONS FOR SUBMITTING PRIOR AUTHORIZATION (PA)

This PA Request form is NOT intended for Bright HealthCare’s Medicare Advantage (“MA”) plans. Please visit [Availity.com](https://www.availity.com) or [BrightHealthCare.com](https://www.brighthealthcare.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 HealthCare 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 |

Turnaround 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 HealthCare. Visit Bright HealthCare’s Provider Portal, [Availity.com](https://www.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 HealthCare’s Utilization Management program, please review our Provider Manual on the Provider Portal, [Availity.com](https://www.availity.com).

Fax—Confidential

| | | | |
|--|--|-------------------------|--|
| To: Bright HealthCare | | Provider/Facility Name: | |
| To Fax: 888-319-6479 | | Date: | |
| Provider / Facility Phone | | Provider / Facility Fax | |
| Re: Behavioral Outpatient Prior Authorization Request: | | | |
| Additional Message: | | | |
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