

**BEHAVIORAL HEALTH Prior Authorization Request Form**

**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			
<input type="checkbox"/> Service request can be <b>reviewed within standard timelines.</b>			
<input type="checkbox"/> The health or life of member <b>may seriously be jeopardized</b> 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: _____	
Behavioral Health Service Being Requested (please select)			
<input type="checkbox"/> Inpatient Hospitalization <input type="checkbox"/> Inpatient Rehabilitation <input type="checkbox"/> Partial Hospitalization Program (PHP)			
<input type="checkbox"/> Intensive Outpatient Program (IOP) <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Outpatient Treatment (list applicable billing codes below)			
<input type="checkbox"/> Other: _____			
<b>Is request associated with a clinical trial?</b> <input type="checkbox"/> Yes or <input type="checkbox"/> No If Yes, enter NCT # _____			
<b>Medication(s):</b> If applicable, list name, dosage, frequency.			
_____			
<b>Anticipated Date(s) of Service:</b> _____			
<b>Diagnosis (ICD -10) Code(s):</b> _____			
CPT/HCPC Codes	# of Hours/Days/Units/Visits	Frequency	
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			
NPI #: _____		Facility Name: _____	
Tax ID #: _____		Street Address: _____	
Facility Type: _____		City: _____	State: _____ Zip: _____
		Phone: _____	Fax: _____
<b>Reimbursement contact (required):</b>		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.**

## 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				
Standard	Urgent	Concurrent	Retrospective	
15 calendar days	72 hours	24 hours	30 calendar days	
States following the timelines above: Alabama, Arizona, Florida, Illinois, Nebraska				
Unique State Requirements				
State	Standard	Urgent	Concurrent	Retrospective
Colorado	5 business days	Lesser of 2 business days or 72 hours	24 hours	30 calendar days
North Carolina	3 business days			30 calendar days
South Carolina	2 business days		1 business day	2 business days
Tennessee	2 business days			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

<b>To:</b> Bright HealthCare	<b>From:</b>
<b>Fax:</b> 1-833-903-1067	<b>Date:</b>
<b>Phone:</b>	
<b>Re: Behavioral Health Prior Authorization Request:</b>	
<b>Additional Message:</b>	