

INPATIENT Prior Authorization Request Form

DATE OF REQUEST: _____ Fax: 1-833-903-1068 Phone: 1-844-929-0162

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 reviewed within standard timelines.			
<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 5): _____			
First Name: _____		Last Name: _____	
Date of Birth: _____		Phone Number: _____	
Admission Type (please select)			
<input type="checkbox"/> Inpatient Surgery/Procedure <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Hospice <input type="checkbox"/> LTACH <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Intraoperative Neuromuscular Monitoring <input type="checkbox"/> Other: _____			
Is request associated with a clinical trial? <input type="checkbox"/> Yes or <input type="checkbox"/> No If Yes, enter NCT # _____			
Is request associated with a transplant? <input type="checkbox"/> Yes or <input type="checkbox"/> No			
Anticipated Date(s) of Service: _____			
Diagnosis (ICD -10) Code(s): _____			
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: _____

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)

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 Medicare Advantage 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.

Definition for Priority Level

- **Standard request:** Bright HealthCare 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 HealthCare receives the request.
- **Expedited request:** Member or any physician (regardless of whether the physician is affiliated with Bright HealthCare), may request that Bright HealthCare 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

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.

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	From:	
Fax: 1-833-903-1068	Date:	
Phone:		
Re: Inpatient Prior Authorization Request:		
Additional Message:		