CONFIDENTIAL - **MEDICARE ADVANTAGE - 2021 RETROSPECTIVE REQUEST**

Bright HealthCare

INPATIENT Authorization Request Form

DATE OF REQUEST: _____ **Phone:** 1-844-926-4522 **Fax**: Reference fax number noted on *brighthealthcare.com/provider/utilization-management*

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					
☐ Service request can be **reviewed within standard timelines.**					
☐ 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)					
☐ Inpatient Surgery/Procedure	☐ Inpatient Rehab	☐ Hospice	☐ LTACH	☐ Skilled Nursing	
☐ *Intraoperative Neuromuscular Monitoring*	☐ Other:				
Is request associated with a clinical trial? ☐ Yes or ☐ No If Yes, enter NCT # _____					
Is request associated with a transplant? ☐ Yes or ☐ 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 or 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.

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.

Fax—Confidential

To: Bright HealthCare	**From:**
	Date:
Phone:	
Re: Inpatient Prior Authorization Request:	
Additional Message:	