

**BEHAVIORAL HEALTH** Prior Authorization Request Form  
 Alabama, Nebraska, South Carolina, Tennessee

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 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 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: _____  |                              |                                 |                         |
| Is request associated with a clinical trial? <input type="checkbox"/> Yes or <input type="checkbox"/> No If Yes, enter NCT # _____   |                              |                                 |                         |
| Medication(s): If applicable, list name, dosage, frequency.<br>_____<br>_____  |                              |                                 |                         |
| 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: _____              |
| <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, Nebraska |                 |            |                  |                  |
| Unique State Requirements                               |                 |            |                  |                  |
| State   | Standard        | Urgent     | Concurrent       | Retrospective    |
| 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

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