ARIZONA, COLORADO, FLORIDA, ILLINOIS, NORTH CAROLINA, OKLAHOMA

AUTHORIZATION REQUEST FORM

CONFIDENTIAL— **INDIVIDUAL & FAMILY PLAN or SMALL GROUP**

Bright HealthCare

MEDICAL 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.

☐ 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:			

Outpatient Service Being Requested (please select)

☐ Ambulatory Surgery ☐ Ambulatory Surgery with Obs ☐ Dental ☐ Dialysis ☐ DME & Supplies

☐ Imaging/Radiology ☐ Home Care ☐ Lab/Diagnostic Testing ☐ Medical Pharmacy – Drug Administration

☐ Observation Stay ☐ Office/Clinic Visits ☐ Rehabilitative/Therapy Outpatient

☐ Other:

Is request associated with a clinical trial? ☐ Yes If Yes, enter NCT # _____

Is request associated with a transplant? ☐ Yes

If this request is related to a transplant request, please include transplant evaluation documentation with your request.

Is request associated with a transplant evaluation? ☐ Yes

Diagnosis (ICD -10) Code(s):					
Place of Service (e.g., Office):					

CPT/HCPC/REV Code(s)	Total Qnty	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 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 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: Arizona, Florida, Oklahoma				
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
Illinois	5 calendar days	48 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.

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.

Approved on 2/16/2022

Fax—Confidential

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

Approved on 2/16/2022