AmeriHealth Caritas Florida

Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
All fields must be completed for the request to be processed.
Please make a selection where applicable throughout the document.

DATE	
TYPE OF REQUEST	_____ URGENT _____ STANDARD _____ RETROSPECTIVE
TREATMENT SETTING	_____ INPATIENT _____ OUTPATIENT
REQUEST TYPE	_____ EXTENSION _____ INITIAL _____ CANCEL _____ CHANGES DOS/SETTING
_____ ADDITIONAL CLINICAL _____ DISCHARGE PLANNING _____ OTHER	
PREVIOUS AUTHORIZATION NUMBER	
CONTACT NAME	
CONTACT PHONE	CONTACT FAX

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID (MEDICAID ID OR HEALTH PLAN ID)		
MEMBER PHONE NUMBER	DATE OF BIRTH	
MEMBER STREET ADDRESS		
CITY	STATE	ZIP

PROVIDER INFORMATION

PROVIDER NAME			
PROVIDER TIN	PROVIDER NPI		
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER		
PROVIDER STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			
FACILITY NAME			
FACILITY TIN	FACILITY NPI		
FACILITY PHONE NUMBER	FACILITY FAX NUMBER		
FACILITY STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)			
REFERRING PHYSICIAN TIN			
REFERRING PHYSICIAN NPI			
REFERRING PHYSICIAN PHONE NUMBER			
REFERRING PHYSICIAN FAX NUMBER			
REFERRING PHYSICIAN STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

MEDICAL SECTION

DIAGNOSIS CODE		

PROCEDURE CODE	START DATE	END DATE	NUMBER OF UNITS	CODE DESCRIPTION

MEDICAL SECTION

NOTES

PLEASE FAX TO **1-855-236-9285.**

FOR ASSISTANCE, PLEASE CONTACT UTILIZATION MANAGEMENT (UM) AT **1-855-371-8074**.

PROVIDERS ARE RESPONSIBLE FOR OBTAINING AUTHORIZATION FOR SERVICES PRIOR TO PROVIDING SERVICE. PLEASE SUBMIT CLINICAL INFORMATION AND ORDERS AS NEEDED TO SUPPORT THE MEDICAL NECESSITY OF THE REQUEST. REQUESTS WILL NOT BE PROCESSED IF ANY OF THE FOLLOWING INFORMATION IS MISSING: APPROPRIATE CLINICAL INFORMATION, SPECIALIST AND/OR PRIMARY CARE CLINICAL SUMMARIES, TREATING PROVIDER, OR CPT AND ICD-10 CODES. AS A REMINDER, AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS SUBJECT TO BENEFIT COVERAGE RULES, INCLUDING MEMBER ELIGIBILITY AND ANY CONTRACTUAL LIMITATIONS IN EFFECT AT THE TIME OF SERVICE. REQUESTS SHOULD BE SUBMITTED VIA FAX OR THE NAVINET WEBSITE. FOR THE MOST UP-TO-DATE LISTING OF SERVICES REQUIRING PRIOR AUTHORIZATION, VISIT THE PROVIDER RESOURCES PAGE AT **WWW.AMERIHEALTHCARITASFL.COM**, OR CALL PROVIDER SERVICES AT **1-800-617-5727**.

URGENT MEDICAL CONDITION: ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.

STANDARD REQUEST: AMERIHEALTH CARITAS FLORIDA HAS SEVEN DAYS TO RENDER A DECISION FROM THE DATE OF REQUEST, AND CAN EXTEND TIME FRAME BY AN ADDITIONAL FOUR DAYS.

EXPEDITED REQUEST: AMERIHEALTH CARITAS FLORIDA HAS TWO DAYS FROM THE DATE OF REQUEST TO RENDER A DECISION, AND CAN EXTEND TIME FRAME BY AN ADDITIONAL BUSINESS DAY. REQUEST MUST INCLUDE A PHYSICIAN'S ORDER STATING THAT WAITING FOR A DECISION UNDER THE STANDARD TIME FRAME COULD ENDANGER THE MEMBER'S LIFE, HEALTH, OR ABILITY TO REGAIN MAXIMUM FUNCTIONALITY, OR WOULD CAUSE SERIOUS PAIN. REQUESTS RECEIVED WITHOUT THIS ORDER WILL BE HANDLED UNDER THE STANDARD TIME FRAME.

PLEASE CONTACT COASTAL CARE SERVICES AT **1-855-481-0505** REGARDING AUTHORIZATION OF DURABLE MEDICAL EQUIPMENT (DME) AND HOME HEALTH SERVICES.

AmeriHealth Caritas™
Florida