Prestige HEALTH CHOICE®
Leading the Way to Quality Care

Prior Authorization Request

To submit requests, please fax completed form to **1-855-236-9285**.
For assistance, please contact Utilization Management (UM) at **1-855-371-8074**.

Please contact Coastal Care Services at **1-855-481-0505** regarding authorization of durable medical equipment (DME) and home health services.

Providers are responsible for obtaining authorization for services prior to providing service. Please submit clinical information and orders as needed to support 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 Availity website. For the most up-to-date listing of services requiring prior authorization, visit the Provider Resources page at **www.prestigehealthchoice.com**, or call Provider Services at **1-800-617-5727**.

Today's date:	Requested start date of service:
☐ **Standard request**	Prestige Health Choice has seven days to render a decision from date of request, and can extend time frame by an additional four days.
☐ **Expedited**	Prestige Health Choice has two days to render decision from date of request, 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.

A. Member information

Medicaid ID number:	Member last name:	Member first name:
Date of birth:	Member address:	
ICD-10 codes:	Member phone number:	Gender: ☐ Male ☐ Female

B. Review type

☐ Initial	☐ *Changes DOS/setting	☐ *Extension of services	☐ Additional clinical
☐ Cancel	☐ *Other (specify)	☐ Discharge planning (services needed for members discharged from inpatient setting such as hospital, skilled nursing facility, etc.)	
*Please specify (if applicable, previous authorization number):			
Service type: ☐ Non-participating ☐ OB/GYN ☐ *Other			

C. Provider information

Referring provider name:	Contact name:		Contact phone number:
Contact fax number:	NPI:	Provider Medicaid ID:	☐ Par ☐ Non-par
Treating provider/facility name:	NPI:	Provider Medicaid ID:	☐ Par ☐ Non-par
Contact name:	Contact phone number:		Contact fax number:

Do not write below this line: Fields to be completed by Prestige Health Choice.

Authorization # _____ Prestige Health Choice UM agent name: _____

Prior Authorization Request

Medicaid ID number: _____

Treatment setting: ☐ Outpatient ☐ Inpatient ☐ Home ☐ In office ☐ *Other

*Please specify (if "Other" selected): _____

D. HCPCS and CPT codes

HCPCS/CPT	Code description	Units	Dates of service	
			From (mm/dd/yyyy)	Through (mm/dd/yyyy)

Other clinical information: Include or attach any clinical and office notes, doctor's orders, labs, and imaging reports to support medical necessity. If this is an out-of-network request, please provide an explanation and complete the non-participating provider form.

E. Rehabilitation services

Type of therapy: ☐ Speech ☐ Physical ☐ Occupational ☐ *Other

*Please specify (if "Other" selected):

Number of units or visits requested:	Previous authorization number:	Dates requested:
☐ Extension ☐ Initial		

Do not write below this line: Fields to be completed by Prestige Health Choice.

Authorization # _____

Prestige Health Choice UM agent name: _____

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