AmeriHealth Caritas Next

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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			
_____ TRANSPLANT EVALUATION NOTIFICATION (IN-NETWORK PROVIDERS ONLY)				
_____ TRANSPLANT LISTING (IN OR OUT OF NETWORK)				
_____ OTHER				
PREVIOUS AUTHORIZATION NUMBER				
CONTACT NAME				
CONTACT PHONE	CONTACT FAX			

MEMBER INFORMATION

LAST NAME			
FIRST NAME			
MEMBER 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: **1-844-314-0362**
UTILIZATION MANAGEMENT DEPARTMENT PHONE: **1-844-486-7701**
TRANSPLANT UNIT FAX NUMBER: **1-844-796-1177**
TRANSPLANT UNIT DIRECT TOLL-FREE NUMBER: **1-833-983-7229**

PROVIDERS ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION FOR SERVICES PRIOR TO SCHEDULING. PLEASE SUBMIT CLINICAL INFORMATION, AS NEEDED, TO SUPPORT MEDICAL NECESSITY OF THE REQUEST. REQUESTS WILL NOT BE PROCESSED IF MISSING CLINICAL INFORMATION 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.

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.

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