Bcbs of ga appeal form

Prior Authorization Request Form
Fax Back To: 1-800-853-3844
Phone: 1-800-711-4555
5 AM – 7 PM PT M-F
or visit www.OptumRx.com and click Health Care Professionals for online real-time submission 24/7

Prior Authorization Request Form

Member Information

Member's Name:
Insurance ID #: Date of Birth:
Address: Apartment #:
City: State: Zip:
Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: NPI#:
Address: City: State: Zip:
Suite Number: Building Number:
Phone Number: Fax number:
Provider's Specialty:

Medication Information*

Medication Name: Strength: ICD9 Code:
Directions for use: Diagnosis:
Is this medication a **New Start**? ☐Yes ☐No
If NO Please provide the following: Initiation Date: Date of Last Dose:
***This information will only be used for coverage determination requests administered by OptumRx.**

Administration Instructions

Medication Administered: Self-Administered ☐ Home Health ☐ LTC ☐ Physician's Office ☐
Is the physician supplying the medication? ☐Yes ☐No

***Please note this request may be denied unless a complete supporting statement is received. Please complete form and fax to OptumRx 1-800-853-3844.**

For urgent or expedited requests please call 1-800-711-4555.

For online real-time submission 24/7 visit www.OptumRx.com and click Health Care Professionals

WellCare

Member ID#		Date Submitted			
Name		DEA# (including X)			
Phone		NPI #			
Dx		Prescriber Name			
Diagnosis		Phone		Fax	
SPECIALTY		Alternate Phone		Contact	

*Form must be completed, signed and submitted by a physician with a Drug Addiction Treatment Act (DATA) waiver*** (XDEA #)*

Drug Requested:

[ ] Suboxone SL Film Tab 8mg/2mg [ ] Suboxone SL Film Tab 2mg/0.5mg
[ ] buprenorphine SL Tab 8mg [ ] buprenorphine SL Tab 2mg

Quantity: ____________ Sig: ______________________________
Start date of this PA: ____________
**Doses above 32 mg per day will NOT be approved.

1. Primary Diagnosis: ICD-9: ______________________________
2. Psychosocial Counseling: ______________________________
   a. Date of last psychosocial counseling session: ____________
   b. Has patient been compliant with all sessions? [ ] Yes [ ] No
3. Please provide plan for method and dates (next 3) of psychosocial counseling going forward:
   a. Method: ______________________________
   b. Dates: (1) ____________ (2) ____________ (3) ____________
4. Must submit most current urine drug screen with this form.
5. Does patient currently abuse alcohol? [ ] Yes [ ] No
6. Has patient taken opioids in the past 30 days? [ ] Yes [ ] No
   a. If yes, please state reason for opioid use: ____________
   b. If yes, has patient experienced a relapse in disease? [ ] Yes [ ] No
7. If requesting doses above 24 mg per day, state clinical reason current dosing limits are being exceeded: ____________
   a. Has patient tried a dose of 16 mg per day? [ ] Yes [ ] No
   b. If yes, provide dates of therapy: ____________
8. Please indicate a taper schedule if dose exceeds 16 mg/day buprenorphine: ____________

** I certify that I have a *Drug Addiction Treatment Act (DATA) waiver.*

Physician Signature ______________________________ **Date** ____________

FAX to: WellCare Pharmacy 1-866-455-6558

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

GENERAL PRESCRIPTION DRUG COVERAGE AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

GENERAL INFORMATION

Request Type (please check one)
☐ Prior Authorization
☐ Step Therapy Exception
☐ Request for Quantity Limit Exception
☐ Appeal
☐ Mandatory Generic Exception
☐ Request for Non-Formulary Exception

Patient Name
Patient's Home Address
City | State | Zip
Date of Birth (mm/dd/yyyy) ___/___/_____ | Contract Number (include prefix)

PRESCRIBER INFORMATION

Prescriber Name
Practice Address
City | State | Zip
Office Phone | Office Fax
Practice Type ☐ PCP ☐ Specialty: ____________
National Provider Identifier (NPI)

REQUEST TYPE

(Please check one) ☐ **Initial Authorization** ☐ **Authorization Renewal** (Please attach any additional medical information.)

TREATMENT INFORMATION

Drug/Strength/Frequency/Quantity Requested: | Duration of Disease (Years):
Place of Services: | Route of Administration: | Healthcare Professional to Administer: ☐ Yes ☐ No
Diagnosis Codes:
Medical rationale for use (include chart notes if possible):

List medications this patient has tried for this condition (include current medications and titration history if applicable)

Drug	Strength/Frequency	Dates of Therapy	Outcome of Therapy
1.			
2.			
3.			
4.			
5.			

Does this patient have any co-morbid conditions that will affect therapy: ☐ Yes ☐ No
If so, please list: ______________________________

Note: Medications received through manufacturer coupons or samples are not accepted as justification of prior therapy.

Prescriber Signature
(Required for processing request)
I certify this information is complete and correct to the best of my knowledge.
Prescriber Signature ____________ Date ____________
Please attach any additional medical justification.

SUBMISSION INSTRUCTIONS

FAX You may fax the signed and completed form to Pharmacy Review at: **1-866-606-6021**

MAIL You may mail the signed and completed form to: **Pharmacy Review**, **Post Office Box 2310 • Auburn, AL 36831**

[illegible]

BCBSNM Medical Management

800-325-8334

IVR Hours of Availability: Monday – Friday 5:00 a.m. – 10:30 p.m. (MT), Saturday 5:00 a.m. – 2:30 p.m. (MT), Sunday – Closed

The table below provides the Blue Cross and Blue Shield of New Mexico (BCBSNM) automated call flow for outpatient preauthorization requests. The left column includes what callers will hear the system say. The right column outlines the options callers may use to respond, along with any special instructions, tips and reminders.

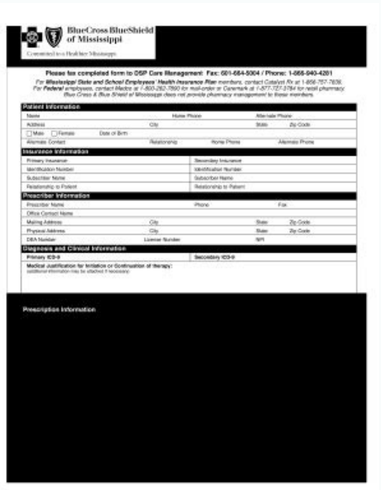
The majority of outpatient services do not require preauthorization. Please note that the automated phone system will only accept requests for services that require preauthorization (reference page 3 for details).

It is highly recommended that providers obtain an eligibility and benefit quote prior to services rendered to determine if preauthorization is required.

Helpful Hints:

- Utilize your key pad when possible.
- Please do not utilize cell phones.
- Minimize background noise.
- Mute your phone when not speaking.

System Prompt:	Touch Tone / Voice Options:
Welcome to Blue Cross and Blue Shield of New Mexico Health Services Department. If you know your party's extension, say "extension." Otherwise, please continue to hold.	To continue your preauthorization request, please continue to hold.
If you're a health care provider, say "provider." If you're a member, say "member."	1. Providers 2. Members
First, is your call regarding a Los Alamos National Laboratories or Sandia National Laboratories member?	1. Yes 2. No
Next, are you calling regarding a preauthorization or a referral?	1. Yes 2. No
If you are a New Mexico provider calling for high technology radiology services, press 1. For outpatient services, press 2. For preauthorization of inpatient, home health or referrals, press 3.	1. High technology radiology services 2. Outpatient services 3. Preauthorization of inpatient, home health, and referrals


BlueCross BlueShield of Mississippi

Please fax completed form to DSP Care Management: Fax: 601-664-5004 / Phone: 1-866-940-4201

Patient Information

Name | Home Phone | Alternate Phone

Address | City | State | Zip Code

☐ Male ☐ Female Date of Birth

Alternate Contact | Relationship | Home Phone | Alternate Phone

Insurance Information

Primary Insurance | Secondary Insurance

Identification Number | Identification Number

Subscriber Name | Subscriber Name

Relationship to Patient | Relationship to Patient

Prescriber Information

Prescriber Name | Phone | Fax

Office Contact Name

Mailing Address | City | State | Zip Code

Physical Address | City | State | Zip Code

DEA Number | License Number | NPI

Diagnosis and Clinical Information

Primary ICD-9 | Secondary ICD-9

Medical Justification for Initiation or Continuation of therapy:

additional information may be attached if necessary

Prescription Information

Bcbs ga appeal timely filing limit.

SHBP has delegated full responsibility for claims administration including medical, pharmacy and wellness appeals to our medical claims administrators, Anthem Blue Cross and Blue Shield, Kaiser Permanente, and UnitedHealthcare; our pharmacy benefits manager, CVS Caremark; and wellness administrator, Sharecare for Anthem and UnitedHealthcare Commercial non-Medicare plan options. Therefore, these types of appeals are outside the scope of eligibility and enrollment appeals handled directly by SHBP through the Tier I Telephone Review and Tier II Formal Appeals Process. Examples of medical, pharmacy or wellness appeals include, but are not limited to adverse actions such as: Medical claims denials Surgical procedure denials Prescription prior authorization denials Wellness incentive credit denials To initiate a medical, pharmacy or wellness appeal, please contact the appropriate administrator via the contact information on the back of your ID Card, contact information available on the SHBP website, or by contacting SHBP Member Services at 800-610-1863 and selecting the prompt to be connected to your administrator. Physicians, physician groups, and facilities may file a Level I Provider Appeal of Blue Cross NC's application of coding and payment rules to an adjudicated claim or of Blue Cross NC's medical necessity determination related to an adjudicated claim. These appeals include dissatisfaction with a claim denial for post-service issues that may be either provider or member liability. These appeals may be submitted internally to Blue Cross NC without written consent from the member. The pre-service review process is not changing. If a pre-service request is denied, providers may contact Healthcare Management and Operations (HCM & O) at 1-800-672-7897 for a pre-service Provider Courtesy Review (PCR). If the PCR is denied, the member can request a Level 1 pre-service appeal of the decision. Providers may not appeal any issues that are considered member benefit or contractual issues. Examples of reviews not eligible for the provider to appeal on their own behalf are: Deductible/coinsurance issues Benefit limitations Benefit Exclusions Membership issues If at any time a member and/or their authorized representative request an appeal during the review of a provider appeal, the member appeal takes precedence. At this time, the provider appeal will be closed. Level I post-service provider appeals for billing/coding disputes and medical necessity determinations are available to physicians, physician groups, physician organizations and facilities and are handled by Blue Cross NC. Providers have 90 calendar days from the claim adjudication date to submit a Level I Post Service Provider Appeal for billing/coding disputes and medical necessity determinations. This process is voluntary. For each step in this process, there are specified time frames for filing an appeal and for notification of the decision. Level I Provider Appeal reviews are completed within 45 calendar days of the receipt of all information. To begin the Level 1 Post Service Provider Appeal process, download, print and fill out the Level I Provider Appeal Form. Process for Billing/Coding Disputes The Level I Provider Appeal Process for billing/coding disputes applies to adjudicated claims related to: Integral part of primary service Mutually exclusive services denials Services not eligible for separate reimbursement Incidental procedure denials Surgical global period denials Process for Medical Necessity The Level I Provider Appeal Process for Medical Necessity applies to adjudicated claims related to: Medical necessity determinations Cosmetic services Investigational/experimental services No authorization for inpatient stay Level I Provider Appeals for billing/coding disputes and medical necessity determinations should be submitted by sending a written request for appeal using the Level I Provider Appeal Form which is available online. With the form, the provider may attach supporting medical information and mail to the following address within the required time frame. Attaching supporting medical information will expedite the handling of the provider appeal. Blue Cross and Blue Shield of North Carolina Provider Appeals Department P.O. Box 2291 Durham, NC 27702-2291

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