CareFirst Medicare Advantage

MEDICAL INJECTION PREAUTHORIZATION REQUEST FORM

FAX COMPLETED FORM WITH SUPPORTING MEDICAL DOCUMENTATION TO: 844-329-0865

SECTION 1 - MEMBER INFORMATION			
First Name:	**Last Name:**	**Date of Birth:**	**Medicare #**

SECTION 2 – HEALTHCARE PROVIDER INFORMATION	
Referring Provider Name: **Office Phone #:**	**Provider's Specialty:** **Referring Provider Fax #:**
Servicing Provider Name: **Office Phone #:**	**Servicing Provider NPI #:** **Servicing Provider Fax #:**
Vendor/Facility Name & Address:	**Vendor/Facility NPI:**
☐ **Outpatient Request**	☐ **Inpatient Request**

SECTION 3 – SERVICE INFORMATION

*CPT codes are used to determine the type of services requested. Authorization of these services assumes that you will bill with codes billable under the current Medicare Fee Schedule. Please contact your Provider Relations representative if you have anyquestions.

Diagnosis Code(s)	Diagnosis Code Description(s)

CPT/HCPCS Code(s)	Dosage/ Number of Units	Frequency/Total number of treatments

Scheduled Date of Service: **(3 month approval intervals)**	**Expected End Date of Service:**

SECTION 4 – SITE OF CARE ADMINISTRATION

☐ **Hospital Infusion**	☐ **Outpatient Infusion**	☐ **Home Infusion**

Rationale for Hospital Infusion:

SECTION 5 – ADDITIONAL INFORMATION

NOTE: This request must be accompanied by a physician's order and/or all other pertinent clinical documentation for appropriate evaluation. Additional documentation may include, but is not limited to:

- Physicians' Orders
- Progress Notes
- Clinical Summary
- Diagnostic Test Results
- Prior Treatments
- Discharge Information

For DME: **Physician's Order Attached** **Certificate of Medical Necessity (CMN) Attached**

SECTION 6 – APPROVAL INFORMATION *(For CareFirst BlueCross BlueShield Medicare Advantage Use Only)*

Authorization #:	**Approval Date Range: —**
Approval Date:	**Reviewer/Approver:**

SECTION 7 – REQUESTOR INFORMATION

Contact Name:	
Callback Phone #:	**Callback Fax #:**
Date of Request: *(All standard requests will be responded to within 14 calendar days of receipt by Health Services Dept.)*	

SECTION 8 – URGENT REQUEST

Provider believes that waiting for a decision under the standard timeframe will place member's life, health or ability to regain maximum function in serious jeopardy.

☐ **Yes, then please call 1-844-386-6762 for expedited review.** ☐ No

If you need to speak to a Utilization Management Representative, **call 1-800-730-8543 Option "8".**

SERVICES ARE NOT CONSIDERED AUTHORIZED UNTIL CAREFIRST BLUECROSS BLUESHIELD MEDICARE ADVANTAGE ISSUES AN APPROVAL. This authorization does not guarantee payment of claim.

All authorizations are subject to eligibility requirements and benefit plan limitations.