

PHONE: 844-873-2905 FAX: 844-873-3163

**PART B DRUG PRIOR AUTHORIZATION REQUEST**

**\*\*\*Form must filled out completely and clinical information attached\*\*\***

|  |  |
| --- | --- |
| Submitted by: (select one)  PCP Office  Specialist  Other | Today’s Date: / / |
| Person to contact for this Submission: | Phone: |

|  |  |  |
| --- | --- | --- |
| **Patient’s Name**: | **DOB:** | **Member ID**: |

|  |  |
| --- | --- |
| **Requesting Provider Section:**  **(i.e. Provider name not location or facility)** | **Servicing Provider/Facility Section:**  (i.e. Facility or Provider Name, May be the same as Requesting Provider) |
| Requesting Provider Name: | Servicing Provider/Facility Name:  Check here if same as Requesting |
| NPI: | NPI: |
| Tax ID: | Tax ID: |
| Address: | Address: |
| Fax: | Fax: |
| Phone: | Phone: |
| **Location Medication will be Administered** Home Office Outpatient Ambulatory Surgery Ctr | |

**Check one and complete the date of service.**

|  |  |  |
| --- | --- | --- |
|  | Proposed Date of Service: | Proposed= Services that have not yet been provided.  **Requests will be authorized up to 90 days.** |
|  | Retro Date of Service: | Retro= Services that have already been provided/started. Retro requests must be submitted from INN providers within 30 days from the date of service **and prior to claim submission.** |

|  |  |  |  |
| --- | --- | --- | --- |
| **ICD-10 Code** | **Diagnosis** | **ICD-10 Code** | **Diagnosis** |
| 1. |  | 3. |  |
| 2. |  | 4. |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Code** | **Name of Medication** | **Route/Dosage/Frequency** | **# of Doses Requested** | **# of Units** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |

This request will be processed per the standard organization determination timeframes. If this request needs to be treated as “expedited”, please note clinical justification why applying the standard timeframe for a determination could seriously **jeopardize the member’s life, health or ability to regain maximum function:**

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to [www.healthteamadvantage.com](http://www.healthteamadvantage.com/) for specific codes requiring a prior authorization.

7800 McCloud Rd, Suite 100, Greensboro, NC 27409 • HealthTeamAdvantage.com • Creation Date: 02/10/2022