Introducing: Standardized Prior Authorization Request Form

The Massachusetts Health Care Administrative Simplification Collaborative*, a multi-stakeholder group committed to reducing health care administrative costs, is proud to introduce the Standardized Prior Authorization Form and accompanying reference guide. *This standard form may be utilized to submit a prior authorization request to a health plan for review along with the necessary clinical documentation to support the request. An accompanying reference guide provides valuable health plan specific information in one location. The Standardized Prior Authorization Form is not intended to replace payer specific prior authorization processes, policies and documentation requirements. The form is designed to serve as a standardized prior authorization form accepted by multiple health plans. It is intended to assist providers by streamlining the data submission process for selected services that require prior authorization. The form does not Support Behavioral Health, Radiology/Imaging, Pharmacy Services or other services that are outsourced by a payer to a vendor. If you are a provider currently submitting prior authorizations through an electronic transaction, please continue to do so. The standardized prior authorization form is intended to be used to submit prior authorizations requests by fax (or mail).*

The following participating health plans now accept the form:

Aetna

Blue Cross Blue Shield of Massachusetts

Boston Medical Center HealthNet Plan

CeltiCare

Fallon Community Health Plan

Harvard Pilgrim Health Care

Health New England

Neighborhood Health Plan

Network Health

Tufts Health Plan

UniCare

UnitedHealthcare

* Participants of the collaborative include: HealthCare Administrative Solutions, Inc., the Employers Action Coalition on Healthcare, Massachusetts Association of Health Plans, Massachusetts Health Data Consortium, Massachusetts Hospital Association, Massachusetts Medical Society, Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan, Neighborhood Health Plan, Network Health, Fallon Community Health Plan, Health New England, Boston Medical Center HealthNet Plan, MassHealth (ad hoc), UniCare, Wellpoint, UnitedHealthcare, Partners HealthCare, Winchester Hospital, North Adams Regional Health Center, Jordan Hospital, Harrington Hospital, Baystate Medical Center, and Atrius Health.

Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THE "STANDARDIZED PRIOR AUTHORIZATION FORM".
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.

The Standardized Prior Authorization Form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements. For payer specific policies, please reference the payer specific websites.

Health Plan:	**Health Plan Fax #:**	***Date Form Completed and Faxed:** ___/___/___

Service Type Requiring Authorization[1, 2, 3] (*Check all that apply*)

Ambulatory/Outpatient Services	**Ancillary**	**Dental**	**Durable Medical Equipment**
☐ Surgery/Procedure (SDC) ☐ Infusion or Oncology Drugs	☐ Acupuncture ☐ Chiropractic ☐ IVF/ART ☐ Non-Participating Specialist	☐ Adjunctive Dental Services ☐ Endodontics ☐ Maxilliofacial Prosthetics ☐ Oral Surgery ☐ Restorative	☐ Prosthetic Device ☐ Purchase ☐ Renal Supplies ☐ Rental
Home Health/Hospice	**Inpatient Care/Observation**	**Nutrition/Counseling**	**Outpatient Therapy**
☐ Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) ☐ Hospice ☐ Infusion Therapy ☐ Respite Care	☐ Acute Medical/Surgical ☐ Long Term Acute Care ☐ Acute Rehab ☐ Skilled Nursing Facility ☐ Observation	☐ Counseling ☐ Enteral Nutrition ☐ Infant Formula ☐ Total Parental Nutrition	☐ Occupational Therapy ☐ Physical Therapy ☐ Pulmonary/Cardiac Rehab ☐ Speech Therapy
Transportation ☐ Non-emergent Ground ☐ Non-emergent Air	☑ **Other—please specify:** Office Visits and Pathology Review		

Provider Information (**Denotes required field*)

***Requesting Provider Name and NPI#:**	***Phone:**	**Fax:**
***Servicing Provider Name and NPI# (and Tax ID if required):** 1851333686 ☐ *Same as Requesting Provider*	***Phone:** 617-632-3455 opt#1	**Fax:** 617-394-2624
***Servicing Facility Name and NPI#:** Dana Farber 1851333686 ☐ *Same as Requesting Provider*	***Phone:** 617-632-3455 opt#1	**Fax:** 617-394-2624
***Contact Person:**	***Phone:**	**Fax:**

Member Information (**Denotes required field*)

***Patient Name:**	***☐ Male ☐ Female**	***DOB:**
Health Insurance ID#:** ***If other insurance, please specify:	***Patient Account/Control Number:**	
Address:	**Phone:**	

Diagnosis/Planned Procedure Information (**Denotes required field*)

***Principal Diagnosis Description:** **ICD-9 Codes:**	***Principal Planned Procedure (Description and CPT/HCPCS Code):** 99201-992015 for 3 visits 88321, 88323, 88342, **# of Units Being Requested:** ☐ Hours ☐ Days ☐ Months ☑ Visits ☐ Dosage
Secondary Diagnosis Description: **ICD-9 Codes:**	**Secondary Planned Procedure (Description and CPT/HCPCS Code):** 99211-99215 for 12 visits **# of Units Being Requested:** ☐ Hours ☐ Days ☐ Months ☑ Visits ☐ Dosage
***Service Start Date:** ___/___/___	***Service End Date:** ___/___/___

[1] Please attach plan specific templates that are required for supporting clinical documentation.
[2] Not all services listed will be covered by the benefits in a member's health plan product.
[3] This form does not replace payer specific prior authorization requirements.

Clear Form

Standardized Prior Authorization Request Form Reference Guide

Participating Health Plans

The Standardized Prior Authorization Request Form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements. For payer specific policies, please reference the payer specific websites.

What is the purpose of the form?

The form is designed to serve as a standardized prior authorization form accepted by multiple health plans. It is intended to assist providers by streamlining the data submission process for selected services that require prior authorization. It is important to note that an eligibility and benefits inquiry should be completed first to confirm eligibility, verify coverage, and determine whether or not prior authorization is required by the member's plan.

Who should use this form?

If you are a provider currently submitting prior authorizations through an electronic transaction, please continue to do so.

The standardized prior authorization form is intended to be used to submit prior authorizations requests by fax (or mail). Requesting providers should complete the standardized prior authorization form and all required health plans specific prior authorization request forms (including all pertinent medical documentation) for submission to the appropriate health plan for review.

The *Prior Authorization Request Form* is for use with the following service types:

Services	Definition (includes but is not limited to the following examples)
Ambulatory/Outpatient Services	Medical services provided to a member in an outpatient setting: hospital outpatient departments, hospital licensed health centers, or other hospital satellite clinics; physicians' offices; nurse practitioners' offices; freestanding ambulatory surgery centers; day treatment centers; members' home.
Ancillary	Acupuncture, chiropractic, infertility, other specialist care.
Dental Services	Endodontic; restorative; oral surgical procedures; maxilliofacial prosthetics; other adjunctive dental services.
Durable Medical Equipment (DME)	Equipment used to fulfill a medical purpose and enable mobility. Can be rented or purchased and can include wheelchairs, walkers, canes, med/surg supplies, renal supplies and prosthetic devices.
Home Health/Hospice	**Home health:** Nurse; home health aide; physical; occupational; speech therapy; respite care; infusion therapy. **Hospice:** Comprehensive services identified and coordinated by an interdisciplinary team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill member or family member.
Inpatient Care/Observation	Inpatient services are medical services provided to a member admitted to an acute inpatient hospital, including long term acute care, acute rehab, and skilled nursing facility. This category also includes medical observation.
Nutrition/Counseling	Medical nutritional therapy is nutritional diagnostic therapy and counseling services for the purpose of management of a medical condition, including enteral nutrition, infant formula, and total parental nutrition.
Outpatient Therapy	Occupational, physical, pulmonary or cardiac, and speech therapy services, including diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, rehabilitate, or prevent worsening functions that affect daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.
Transportation	Non-emergent ground and non-emergent air models of transportation, including ambulance.

The form is currently ***not*** intended to:

- Capture supporting clinical documentation.
  - Including plans specific templates.
- Support Behavioral Health, Radiology/Imaging, Pharmacy Services or other services that are outsourced by a payer to a vendor.

Defining Data Elements

Provider Information	• The requesting provider is the physician and the servicing provider can be the same physician as the requesting provider or the facility where the service will be provided. • The contact person is the person who is filling out the form.
Diagnosis/Planned Procedure Information	• CPT codes are not required by every plan, but are required by some. Please consult the plan specific websites to see if CPT codes are required for prior authorization. • Examples of services that align with # of units being requested: - Hours: Home health aide - Days: Home health; physical therapy - Months: DME - Visits: Outpatient therapies; home health (RN, PT, OT) - Dosage: Different measurements (mg, g, etc.) that can be used for infusion
Other Information	• Any supporting clinical documentation should be submitted in addition to this form for prior authorization approval. • For services not listed, please refer to plan specific medical policies for prior authorization requirements. • Some services may require physician signature and should be submitted with the supporting clinical documentation.

Specific Prior Authorization Requirements

Please refer to the following payer Web sites for additional information regarding plan specific documentation requirements for services that require prior authorization.

Aetna

BCBSMA

BMCHP – Information about Prior Authorization in our 1) Provider Manual; 2) PA Matrix; and 3) Clinical Policies

CeltiCare

FCHP

Harvard Pilgrim

Health New England

NHP

Network Health

Tufts Health Plan – Clinical Resources/Medical Necessity Guidelines

UniCare

United Healthcare