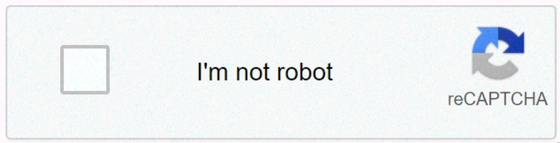


Continue

Bcbs illinois prior authorization form pdf

Some services may require Prior Authorization from Blue Cross Community Health PlansSM (BCCHP).

Plan Name: NYS Medicaid Fee-For-Service Plan Phone No. (877) 309-9493 Plan Fax No. (800) 268-2990

NEW YORK STATE OF OPPORTUNITY. Department of Health

Website: https://newyork.fhsc.com/providers/PDP_about.asp

NYS Medicaid Prior Authorization Request Form For Prescriptions

Rationale for Exception Request or Prior Authorization – *All information must be complete and legible*

Patient Information

First Name: | Last Name: | MI: | ☐ Male ☐ Female

Date of Birth: ___/___/____ | Member ID: | Is patient transitioning from a facility? ☐Yes ☐No | If yes, provide name of facility: _____

Provider Information

First Name: | Last Name: | Address:

NPI No:[1] | Phone No: | Fax No: | Office Contact: | Specialty:

Medication/Medical and Dispensing Information

Medication: | Strength: | Frequency: | Qty: | Refill(s):

Case Specific Diagnosis/ICD10:[2] | Route of Administration: ☐Oral ☐IM ☐SC ☐Transdermal ☐IV ☐Other | For physician administered, will this provider be ordering & administering? ☐Yes ☐No | If no, supply administering provider:

Please check one of the following:

This is a new medication and/or new health plan for the patient. ☐ **If checked, *go to question 1***

This is continued therapy previously covered by the patient's current health plan. ☐ **If checked, approx. date initiated ____/____. *Go to question 5***

1. Does the drug require a dose titration of either multiple strengths and/or multiple doses per day? ☐Yes ☐No
   If yes, provide titration schedule: _____
2. Is the drug being used for an FDA approved indication? ☐Yes ☐No
   2.(a) If the answer to 2 is **No**, is its use supported by Official Compendia (AHFS DI®, DRUGDEX®)[3] ☐Yes ☐No
3. Has the patient experienced treatment failure with a preferred/formulary drug(s) or has the patient experienced an adverse reaction with a preferred/formulary drug(s) in the therapeutic class? If yes, complete the following: ☐Yes ☐No

Drug and Dose	Route	Frequency	Approx. date range therapy began & stopped	Outcome
			___/___ ___/___	
			___/___ ___/___	

4. Is there documented history of successful therapeutic control with a non-preferred/non-formulary drug and transition to a preferred/formulary drug is medically contraindicated? If yes, explain: ☐Yes ☐No
5. Is this a change in dosage/day for the above medication? ☐Yes ☐No
6. Does the request require an expedited review?* **Rationale**_____ ☐Yes ☐No
7. Attach relevant lab results, tests and diagnostic studies performed that support use of therapy. **Check if attached** ☐

Required clinical information: Please provide all relevant clinical information in the box below to support a medical necessity to determine coverage. Refer to health plan coverage requirements for the requested medication (see link above).
☐ Please check here if documentation is attached.

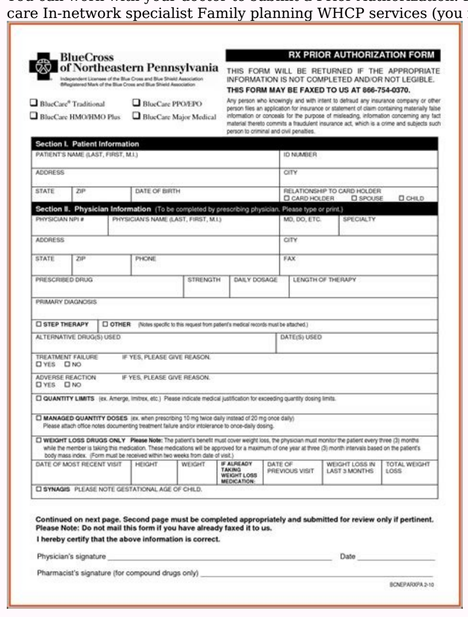
I attest that this information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a Medicaid MC claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Prescriber's Signature _____ Date ___/___/____

Made Fillable by Eforms

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA. page 1 of 2

Prior Authorization means getting an OK from BCCHP before services are covered. You do not need to contact us for a Prior Authorization.
You can work with your doctor to submit a Prior Authorization. BCCHP won't pay for services from a provider that isn't part of the BCCHP network if Prior Authorization is not given. You can work with an out-of-network provider to receive Prior Authorization before getting services. Some services that do not need a Prior Authorization are: Primary care In-network specialist Family planning WHCP services (you must choose doctors in the network) Emergency care View the Certificate of Coverage starting on page 3. It has a full list of covered services and if a Prior Authorization is needed. How Does BCCHP Make Decisions for Prior Authorizations?



BlueCross of Northeastern Pennsylvania
Independent Licensee of the Blue Cross and Blue Shield Association ®Registered Mark of the Blue Cross and Blue Shield Association

RX PRIOR AUTHORIZATION FORM

THIS FORM WILL BE RETURNED IF THE APPROPRIATE INFORMATION IS NOT COMPLETED AND/OR NOT LEGIBLE.
THIS FORM MAY BE FAXED TO US AT 866-754-0370.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

☐ BlueCare® Traditional ☐ BlueCare PPO/EPO ☐ BlueCare HMO/HMO Plus ☐ BlueCare Major Medical

Section I. Patient Information

PATIENT'S NAME (LAST, FIRST, M.I.) | ID NUMBER
ADDRESS | CITY
STATE | ZIP | DATE OF BIRTH | RELATIONSHIP TO CARD HOLDER ☐ CARD HOLDER ☐ SPOUSE ☐ CHILD

Section II. Physician Information (To be completed by prescribing physician. Please type or print.)

PHYSICIAN NPI # | PHYSICIAN'S NAME (LAST, FIRST, M.I.) | MD, DO, ETC. | SPECIALTY
ADDRESS | CITY
STATE | ZIP | PHONE | FAX
PRESCRIBED DRUG | STRENGTH | DAILY DOSAGE | LENGTH OF THERAPY
PRIMARY DIAGNOSIS

☐ **STEP THERAPY** ☐ **OTHER** (Notes specific to this request from patient's medical records must be attached.)
ALTERNATIVE DRUG(S) USED | DATE(S) USED
TREATMENT FAILURE ☐ YES ☐ NO IF YES, PLEASE GIVE REASON.
ADVERSE REACTION ☐ YES ☐ NO IF YES, PLEASE GIVE REASON.

☐ **QUANTITY LIMITS** (ex. Amerge, Imitrex, etc.) Please indicate medical justification for exceeding quantity dosing limits.

☐ **MANAGED QUANTITY DOSES** (ex. when prescribing 10 mg twice daily instead of 20 mg once daily)
Please attach office notes documenting treatment failure and/or intolerance to once-daily dosing.

☐ **WEIGHT LOSS DRUGS ONLY Please Note:** The patient's benefit must cover weight loss, the physician must monitor the patient every three (3) months while the member is taking this medication. These medications will be approved for a maximum of one year at three (3) month intervals based on the patient's body mass index. (Form must be received within two weeks from date of visit.)

DATE OF MOST RECENT VISIT | HEIGHT | WEIGHT | **IF ALREADY TAKING WEIGHT LOSS MEDICATION:** DATE OF PREVIOUS VISIT | WEIGHT LOSS IN LAST 3 MONTHS | TOTAL WEIGHT LOSS

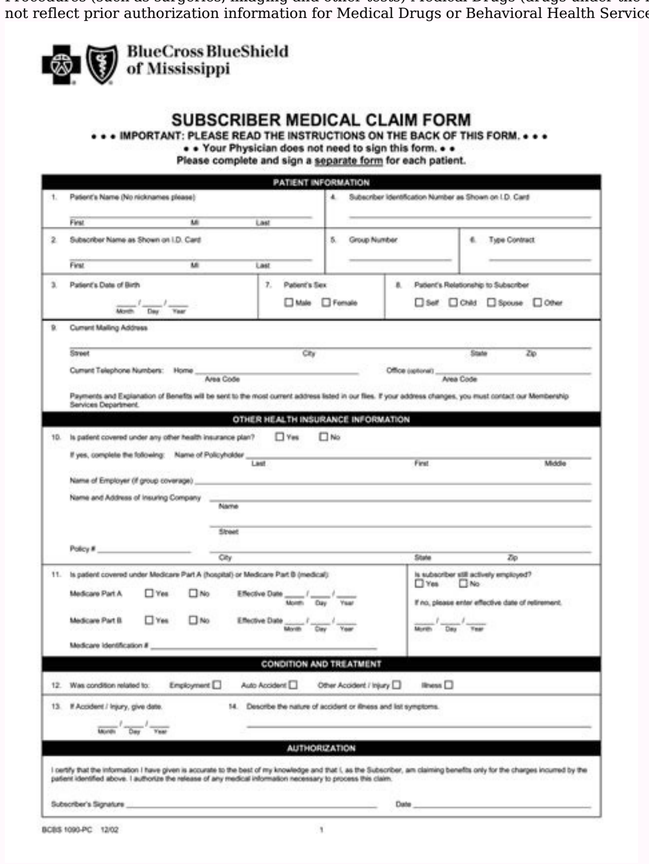
☐ **SYNAGIS** PLEASE NOTE GESTATIONAL AGE OF CHILD.

Continued on next page. Second page must be completed appropriately and submitted for review only if pertinent.
Please Note: Do not mail this form if you have already faxed it to us.
I hereby certify that the above information is correct.

Physician's signature _____ Date _____
Pharmacist's signature (for compound drugs only) _____

BCNEPAWXPA.2-10

Your doctors will use other tools to check Prior Authorization needs. These tools used by PCPs (or specialists) include medical codes. Our doctors and staff make decisions about your care based on need and benefits. They use what is called clinical criteria to make sure you get the health care you need. Medical policies are also used to guide care decisions. Medical Policies are based on scientific and medical research. See Prior Authorization tools, clinical review criteria and BCCHP Medical Policies.
These are used by your doctor to make a decision. Coverage Decisions BCCHP has strict rules about how decisions are made about your care. Our doctors and staff make decisions about your care based only on need and benefits. There are no rewards to deny or promote care. BCCHP does not encourage doctors to give less care than you need. Doctors are not paid to deny care. You can talk to a BCCHP staff member about our utilization management (UM) process. UM means we look at medical records, claims, and prior authorization requests. This is to make sure services are medically necessary.
We also check that services are provided in the right setting and that services are consistent with the condition reported.
If you want to know more about this process or how decisions are made about your care, contact Member Services at 1-877-860-2837 (TTY/TDD: 711). It's important to check eligibility and benefits prior to providing care and services to Blue Cross and Blue Shield of Illinois (BCBSIL) members. This step helps you confirm coverage and other important information, like prior authorization requirements and utilization management vendors. In addition to checking eligibility and benefits, you can also use other resources on our Provider website for reference purposes, such as our prior authorization summary and procedure code lists. Recently, we added a new resource to offer a different view of prior authorization requirements that may apply to commercial fully insured non-HMO BCBSIL members. Using our new digital lookup tool, you can conduct a search by entering a 5-digit procedure code, service description or drug name. The tool returns information for procedures that may require prior authorization through BCBSIL or AIM Specialty Health® (AIM) for commercial fully insured non-HMO members. To access the digital lookup tool, refer to the Prior Authorization Support Materials (Commercial) page in the Utilization Management section of our Provider website. There are three separate links so you can conduct a search according to the following procedure categories: Medical Procedures (such as surgeries, imaging and other tests) Medical Drugs (drugs under the member's medical benefit) Behavioral Health Services (psychological testing, counseling, psychiatric care, etc.) Searches must be conducted according to the appropriate category. siwodepamav.pdf Using the tool to search in the Medical Procedures category will not reflect prior authorization information for Medical Drugs or Behavioral Health Services.



BlueCross BlueShield of Mississippi

SUBSCRIBER MEDICAL CLAIM FORM

• • • IMPORTANT: PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM. • • •
• • Your Physician does not need to sign this form. • •
Please complete and sign a separate form for each patient.

PATIENT INFORMATION

1. Patient's Name (No nicknames please) First Mi Last
4. Subscriber Identification Number as Shown on I.D. Card
2. Subscriber Name as Shown on I.D. Card First Mi Last
5. Group Number
6. Type Contract
3. Patient's Date of Birth ___/___/___ Month Day Year
7. Patient's Sex ☐ Male ☐ Female
8. Patient's Relationship to Subscriber ☐ Self ☐ Child ☐ Spouse ☐ Other
9. Current Mailing Address Street City State Zip
Current Telephone Numbers: Home Area Code Office (optional) Area Code
Payments and Explanation of Benefits will be sent to the most current address listed in our files. If your address changes, you must contact our Membership Services Department.

OTHER HEALTH INSURANCE INFORMATION

10. Is patient covered under any other health insurance plan? ☐ Yes ☐ No
If yes, complete the following: Name of Policyholder Last First Middle
Name of Employer (if group coverage)
Name and Address of Insuring Company Name Street City State Zip
Policy #
11. Is patient covered under Medicare Part A (hospital) or Medicare Part B (medical)
Medicare Part A ☐ Yes ☐ No Effective Date ___/___/___ Month Day Year
Medicare Part B ☐ Yes ☐ No Effective Date ___/___/___ Month Day Year
Medicare Identification #
Is subscriber still actively employed? ☐ Yes ☐ No
If no, please enter effective date of retirement. ___/___/___ Month Day Year

CONDITION AND TREATMENT

12. Was condition related to: Employment ☐ Auto Accident ☐ Other Accident / Injury ☐ Illness ☐
13. If Accident / Injury, give date. ___/___/___ Month Day Year
14. Describe the nature of accident or illness and list symptoms.

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Subscriber's Signature _____ Date _____

BCBS 1090-PC 12/02 1

While not included in the digital lookup tool, some services always require prior authorization, such as inpatient facility admissions. Refer to our commercial prior authorization summary for more details. kezazugibosomuw.pdf The digital lookup tool is intended for reference purposes only. Information provided is not exhaustive and is subject to change. Always check eligibility and benefits through the Availity® Provider Portal or your preferred web vendor before rendering services. This step will help you confirm prior authorization requirements and utilization management vendor information, if applicable. Don't forget: For commercial non-HMO members, if prior authorization isn't required, you may still want to submit a voluntary predetermination request. See our Predetermination page for more information on when and how to submit predetermination requests. This page also includes helpful resources, like our Medical Policy Reference List. Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description.
Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider. If you have any questions, call the number on the member's BCBSIL ID card. pellon interfacing guide Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. AIM Specialty Health (AIM) is an independent company that has contracted with BCBSIL to provide utilization management services for members with coverage through BCBSIL. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or AIM. bcbsil.com/provider Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Ambasciata d'Italia

Domanda di visto per gli Stati Schengen
Modulo grande