Standard Prior Authorization Request Form

CarePartners of Connecticut MEDICARE ADVANTAGE

Please complete this form to request prior authorization for CarePartners of Connecticut Medicare Advantage members. Incomplete submissions may be returned unprocessed. Fax completed forms to **857-304-6463** for outpatient or **857-304-6410** for inpatient.

The list of services below may not be all-inclusive. For up-to-date details on services requiring prior authorization, please refer to our Medical Necessity Guidelines and our Prior Authorization and Inpatient Notification List, found on on our provider website at www.carepartnersct.com/for-providers.

***Date Form Completed and Faxed:** _____ * *required field*

☐ **Expedited Request**
(*by checking this box I certify that this request meets the below criteria for being Expedited and will supply justification*)

Criteria for Expedited: Waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

Justification for Expedited: (*attach pages if additional space is needed)*

Service Type for Authorization Request[1, 2] (*Check all that apply*)

Ambulatory/Outpatient Services
- ☐ Surgery/Procedure (SDC)
- ☐ Infusion or Oncology Drugs

Ancillary
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ IVF/ART
- ☐ Non-Participating Specialist

Durable Medical Equipment
- ☐ Prosthetic Device
- ☐ Purchase
- ☐ Renal Supplies
- ☐ Rental

Inpatient Care/Observation
- ☐ Acute Medical/Surgical
- ☐ Long Term Acute Care
- ☐ Acute Rehab
- ☐ Skilled Nursing Facility
- ☐ Observation

Transportation
- ☐ Non-emergent Ground
- ☐ Non-emergent Air

☐ **Other** (*please specify*)

[1] Please include any supporting clinical documentation to support this prior authorization request.

[2] Not all services listed will be covered by the benefits in a member's health plan product.

Provider Information

*Requesting Provider: _____ NPI#: _____ *Phone: _____ Fax: _____

*Servicing Provider: _____ NPI#: _____ *Phone: _____ Fax: _____

☐ Same as Requesting Provider Tax ID (*if required*): _____

*Servicing Facility: _____ NPI#: _____ *Phone: _____ Fax: _____

☐ Same as Requesting Provider

*Contact Person Name: _____ *Phone: _____ Fax: _____

Member Information

*Patient Name: _____ *Gender: ☐ Male ☐ Female *DOB: _____

*Health Insurance ID#: _____ *If other insurance, please specify*: _____

Address: _____ Phone: _____

Diagnosis/Planned Procedure Information

*Principal Diagnosis Description: _____

ICD-10 Codes: _____

*Principal Planned Procedure (*Description and CPT/HCPCS Code*): _____

# of Units Being Requested:
☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage

Secondary Diagnosis Description: _____

ICD-10 Codes: _____

Secondary Planned Procedure (*Description and CPT/HCPCS Code*): _____

# of Units Being Requested:
☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage

*Service Start Date: _____ *Service End Date: _____

CLEAR FORM