

# Outpatient Medical Prior Authorizations

Provider Portal User's Guide

## **Outpatient Medical Prior Authorizations**

The following guide provides step by step instructions for how to submit a medical prior authorization using the CareFirst Provider Portal.



#### Prior Authorization Landing Page

If you have entered any prior authorizations, they will show up here. You can also expand your view by clicking on *View my Tax ID*. This will show all authorizations entered for your tax ID by any user.

To begin entering a Prior Authorization, click *Add New* and select *Medical Prior Authorization*.

#### Search for and Select a Member

From here, you will enter the *Member ID* (including prefix) and click *Search*.

**Important Note:** Your Prior Authorization will remain in draft until it is submitted. Drafts remain on the roster for 72 hours. If you navigate away from this page it is automatically saved as a draft.

| Prior A  |                              | Search .<br>Advanced Basech i Check Garate                 | Add New   |   |
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|  |                              |  | Genetic Testing Authorization                     |   |
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| Add New - Medical Prior Authorizati  | on                           |  | Delete this Draft 🛛 🚔 Print Page                  |   |
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| * indicates required   |                              |  |   |   |
| - Search for a Member  |                              |  |   |   |
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| Member ID* Date of Birth   |                              |  |   |   |
| Search for a Member  | Enter minimum 2 characters   | Enter minimum 2 characters                                 | Search  |   |
| Search for a Member  | Enter minimum 2 characters   | Enter minimum 2 characters                                 | Search  |   |
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Select the appropriate Member My WorkList Draft 🛞 Stets a Monter Description of Description Call prior to submitting this regulation of Description of Descriptio and click Next. Delete this Draft A Print Page Search for a Member Member 0 & Date of Birth Lost Name First Name XXXXXXXXXXXX Enter entire ID with format.men/ddiryyyy Enter minimum 2 characters Enter minimum 2 characters First Name Reset Search 4 Result(s) Found - Please select a Member Select Member ID 
Last Name First Name ate of Birth MALE MEMBER 1 1/5/2013 NAME MEMBER 2 MEMBER 3 MEMBER 4 NAME FEMALE DEPENDENT CHILD SELF нмо нмо 8/21/2010 9/15/1972 MALE NAME 2/13/1968 SPOUSE HMO Next



#### **Enter Request Details**

Select the *Urgency and Place* of Service from the drop-down options. (Urgency refers to the patient's status, not the urgency of the notification.)

| Je select the S | tart Date/ End Date before en.c. the D                                     | agnosis codes. All fields with an asterisk (*) are required to be completed before proceeding to next screen.                                     |
|-----------------|--|---|
| rgency*         | Place of Service*  | Notification Date*  |
| ROUTINE V       | Select One<br>AMBULANCE - AIR<br>AMBULATORY SURGICAL CENTER<br>HOME        | 12/20/2016 Back Ned   |
| DISCLAIME       | OFFICE<br>OUTPATIENT HOSPITAL<br>quired by State law, this poly - not a gr | arantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts such as deduc |

**Important Note:** *Place of Service* within the Prior Authorization section is different than the *Place of Service* option within the *Inpatient Notifications* section. If you do not see the intended place of service, check to ensure you are in the correct tab.

Next, you will enter the *Procedure Code/Description.* 

Click on the **Q** to begin your search.

You may enter up to two Procedures. Any additional procedure codes can be added to the comments section.

From here, you will enter the Type (CPT or HCPCS), Code and/or Description and click Search.

Once, you find the Code Description you are looking for, highlight your selection by clicking on it and then click *OK*.

| To enter Procedure click Search Icon     To enter Procedure click Search Icon     To     To enter Procedure     To       | ۲   |  | Procedure Medical Policy | Notification Required? |
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| arch for a Procedure  arch for a Procedure  arch for a Procedure  by  code  code code   |   | To enter Procedure click Search Icon   | 2                        |                        |
| and for a Procedure by entering Type, Cade and/or Description  as COP  a endor Description  Code  Code Code Description  Code Descrip | arch for a  | Procedure  | X                        |                        |
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| 7164 PHYSICAL THERAPY RE-EVAL EST PLAN CARE 20 MINS   | 97001<br>97750<br>97799<br>95954<br>97002<br>76818<br>97161<br>97162                            | UNLISTED PHYSICAL WEAVINGMERHAR SERVICE/PROC<br>RXXPHYSICAL EEG ACTIVAJ PHYSICHA TETENDANCE<br>PHYSICAL THERAPY RE-VALUATION<br>FETAL BIOPHYSICAL PHOFILE INON STRESS TESTING<br>PHYSICAL THERAPY EVALUATION IOW COMPLEX 20 MINS<br>EVANION THERAPY EVALUATION IOW COMPLEX 20 MINS   |                          |                        |
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|   | 97001<br>97750<br>97799<br>95954<br>97002<br>76818<br>97002<br>97161<br>97162<br>97163<br>97164 | UNLISTED PHYSICAL WEAVINGWEARD SERVICE/PROC<br>RXPHPISICAL EEG ACTIVA) PHYSICIAL ATTENDANCE<br>PHYSICAL THERAPY RE-VALUATION<br>FETAL BIOPHYSICAL PHOFILE INO-STRESS TESTING<br>PHYSICAL THERAPY EVALUATION LOW COMPLEX 20 MINS<br>PHYSICAL THERAPY EVALUATION MIGH COMPLEX 45 MINS<br>PHYSICAL THERAPY EVALUATION HIGH COMPLEX 45 MINS<br>PHYSICAL THERAPY RE-EVAL EST PLAN CARE 20 MINS    |                          |                        |
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**Important Note:** You must ensure your selection is highlighted prior to clicking *OK* even if it is the only option listed.

Enter the *Units, Start Date* and *End Date*.

The *Prior Auth Required?* column will provide a **yes** or **no** response dependent upon the member's contract, place of service and procedure code selected.



**Important Note:** The start date cannot be more than 3 days after the date of service. If you need to enter a retro authorization, use today's date as the start date and then enter the end date. Enter the correct start date in the Comments section. The start date can be up to 31 days in the future.

### Next, you will enter the *Diagnosis Code/Description.*

You can type either the code or the description and then make your selection from the drop-down list.

Click on the sicon to enter additional diagnosis information (if applicable). Please select the Primary Diagnosis by clicking on the radio button under the Primary column **Primary**.

You may enter up to six Diagnosis Codes. Any additional codes can be added to the Comments section.

| Primary    | Diagnosis Code / Description*   |                   |
|------------|---|-------------------|
| 0          |   | 1                 |
|            | <b>4</b> .  |                   |
|            |   |                   |
|            |   |                   |
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| ou may ei  | nter up to 6 Diagnosis. Please select the Primary Diagnosis.Enter minimum 3 characters of code/ description   | on to search.     |
| Primary    | Diagnosis Code / Description*   |                   |
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|            | M54.5 LOW BACK PAIN   | _                 |
|            | S39 92YA LINSPEC IN JUDY LOWED BACK IE  |                   |
| oviae.     | DOT TO THE PROPERTING AND THE PROPERTY OF THE |                   |
| ase pick a | L02.222 FURUNCLE OF BACK [EXCEPT BUTTOCK]   |                   |
|            | L02.232 CARBUNCLE OF BACK [EXCEPT BUTTOCK]  |                   |
|            | L89.103 PRESSRE ULCR UNSPE BACK STAGE 3   |                   |
| ase selec  | L03.312 CELLULITIS OF BACK [EXCEPT BUTTOCK]   |                   |
| vider Nar  | S30.810A ABRASION LOWER BACK & PELVIS, IE   | ~                 |
|            | SJU.0 TUD ADRASION LOWER DACK & PELVIS, SE  |                   |
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| u may en   | ter up to 6 Diagnosis. Please select the Primary Diagnosis.Enter minimum 3 characters of code/ desc   | ription to search |
| rimary     | Diagnosis Code / Description*   |                   |
| 2          | 154.5 LOW BACK PAIN   |                   |
| 0          |   |                   |

Next you will enter the Facility Information (if applicable).

You can select a Provider/Facility within your group, or one not in your group from the drop-down.

When you select a *Facility within your group*, you can then select the one you need from the drop-down.

Note: You can set this as My Favorite.

| Please pick a method to select the Facility:   | Select a Facility within my group |   |
|--|-----------------------------------|---|
| Please select a Facility for   |                                   |   |
| Facility V vo Select one<br>ABC MEDICAL CENTER<br>Sele this F{xyz SUB ACUTE  |                                   |   |
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|  |                                   |   |
| -Facility Information  |                                   |   |
| Please pick a method to select the Facility:   | Select a Facility within my group |   |
| Facility Information<br>Please pick a method to select the Facility:<br>Please select a Facility for this Request:   | Select a Facility within my group |   |
| Facility Information<br>Please pick a method to select the Facility:<br>Please select a Facility for this Request:   | Select a Facility within my group |   |
| Facility Information Please pick a method to select the Facility: Please select a Facility for this Request:     Select this Facility as 'My Favorite'   | Select a Facility within my group | BLUECHOICE NETWORK GHMSI SELECT<br>PREFERRED PATICIPATING PROVIDER<br>CODELL PATICIPATING PROVIDER  |
| Facility information     Please pick antibility for this Request:     Please select a Facility for this Request:     Select this Facility as 'My Favorite'   | Select a Facility within my group | BLUECHOICE NETWORK GINNSI SELECT<br>PREFERIED PROVORK GINNSI<br>GLOBAL PARTICIPATING PROVIDER<br>NETWORK<br>NETWORK<br>MORDOI   |
| Facility Information     Please pick amend to select the Facility:     Please pick amend to select the Facility:     Please select a Facility for this Request:     End of the facility as My Facore     Select this Facility as My Facore | Select a Facility within my group | BLUECHDICE NETWORK GHMSI SELECT           PRESERVED PROJEKT NETWORK GHMSI SELECT           NETWORK CHARAN INFORMER           NETWORK CHARAN INFORMER           NETWORK CHARAN INFORMER           XACRED FED HSPITAL   |
| Facility Information     Prese pick a method to select the Facility:     Prese pick a method to select the Facility and the select the Facility and the select the Facility as My Fevore     Select the Facility as My Fevore              | Select a Facility within my group | BLUECHOICE NETWORK GHMSI SELECT<br>90: PREFERED PROVIDER NETWORK GHMSI<br>GLOBAL PARTICIPATING PROVIDER<br>10: NOCREDITED HOSPITAL<br>90: MCARLES STEAL TIMORE MD 21204   |
| Facility Information     Please pick are motod to select the Facility:     Please select a Facility for this Request:     F     Exclusion:     Select this Facility as My Favorite   | Select a Pacility within my group | BLUECHOICE NETWORK GHMSI SELECT           9I:         PREFERAED PROVIDER NETWORK GHMSI<br>GLOBAL PARTICIPATING PROVIDER           10:         NETWORK,           32:         MAGDOI           33:         ACCREDITED HOSPITAL           4701 M CHARLES ST BALTIMORE.MD 21204         amber:           403492000         Control |

When you select a *Facility not in my group*, you are then prompted to enter the *Facility ID* and/ or *Facility Name* along with the *Facility Sub-Type and State* and click *Search*.

| Please pick a method to select the Facility: Starch for Facility not an my o<br>Enter the Facility ID<br>Inter minimum 3 charact | raciity Sub-Type<br>Select One | Rest |  |
|--|--------------------------------|------|--|
|  | State V                        |      |  |

Next you will enter the Provider Information.

There are three options to enter the provider information:

- A provider within your group (tax-id)
- A provider not in your group (tax-id)
- Enter provider information

**Important Note:** Only use *Enter Provider Information* as a last resort. Using this option causes the case to pend for review.

When selecting a *Provider not in my group* there are three different ways you can search for the provider.

- By Provider ID and Provider Name
- And/or Practice Name or Provider Last Name

Within the Provider ID Type search, you can search by NPI or the provider's CareFirst Provider Number.

Once you have entered all the required information, click *Search*. You will be provided a list of providers that match your search criteria. Select the provider you need and click *Next*.

Note: No Match indicates the provider's network affiliation does not match the member's contract type.







| ease         | e select             | which type of           | Professional Provider                    | r for this Request Sear | ch for Provider not in | my group 👻               |  |                    |
|--------------|----------------------|-------------------------|--|-------------------------|------------------------|--------------------------|--|--------------------|
| leas<br>Prov | se searc<br>rider ID | h by the Provi<br>Type* | der ID Type and/or Pro<br>Provider ID*   | ovider Name Type:       |                        | Name Type*               | Name*  |                    |
| Sele         | ect one              | -                       |  |                         | AND/OR                 | Practitioner Last Name 🗢 | smith  | Reset              |
| Re           | esult(s              | ) Found -               | Enter minimum 5 digit<br>Please select a | s<br>a Provider.        |                        |                          | Enter minimum 5 characters                   |                    |
|              | Select               | Provider<br>ID          | Practitioner<br>ID                       | Practice Name           | Practitioner<br>Name   | Specialty                | Practitioner Address                         | Networks           |
|              | 0                    | AU. 20                  | хххххх                                   | ABC PRACTICE            | JANE DOE               | GENERAL SURGEON          | 123 ANY STREET, SUITE 1,<br>TOWSON, MD 21286 | No Match           |
| ×            | 0                    | X00001                  | XXXXXXX                                  | XYZ PRACTICE            | JOHN DOE               | PSYCHOLOGIST             | 100 ANY AVENUE,<br>BALTIMORE, MD 21204       | BLUECHOICE NETWORK |
| ×            | 0                    | X00002                  | хххххх                                   | LMN PHYSCIAN<br>GROUP   | SALLY SMITH            | HEMATOLOGY               | 500 ANY BLVD, SUITE 104<br>HANOVER, PA 17331 | No Match           |

You will then be prompted to complete a questionnaire, if applicable.

| Medical Outpatient Questionnaire     In Progress Questionnaire       Medical Outpatient Questionnaire     Yas     No       * Can this service be performed in a freestanding In-Network factby?     Yas     No       * If not, is a letter of medical necessary submitted with this request?     Yas     No       * Are reset office notes and restment plas submitted?     Yas     No       * Are reset office notes and depands tubbles submitted?     Yas     No  | Questionnaire(s)   | Action                    |
|--|--|---------------------------|
| Medical Outpatient Questionnaire  Can this service be performed in a freestanding in-Network facthy?  Inot, is a letter of medical necessally submitted with this request?  A represent locks and depander submitted?  A reportient locks and depander submitted?  Yes Ino Are performed locks and depander submitted?  Yes Ino  | Medical Outpatient Questionnaire   | In Progress Questionnaire |
| Medical Outpatient Questionnaire  Can this service be performed in a freestanding in-Network facity?  I find, is a latter of medical necessity submitted with this request?  I find, is a latter of medical necessity submitted with this request?  Are recent office noles and treatment plan submitted?  Are profilent tiles submitted?  I for posses  I for pos |  |                           |
| Can this service be performed in a freestanding in-Network facility?     Ves 0 No   | Medical Outpatient Questionnaire   |                           |
| If not, is a letter of medical necessary submitted with this request?  | Can this service be performed in a freestanding In-Network facity?   | 💮 Yes 💿 No                |
| * Are recent office notes and treatment plan submitted? Of Yes 💿 No  | If not, is a letter of medical necessity submitted with this request?  | 💿 Yes 💿 No                |
| Are pertinent labs and diagnostic studies submitted? (if no, please submit as soon as possible in order for review to be   | Are recent office notes and treatment plan submitted?  | 🔘 Yes 🔘 No                |
| competed)  | Are pertinent labs and diagnostic studies submitted? (if no, please submit as soon as possible in order fo<br>competted) | r review to be 📀 Yes 💿 No |

You can also attach any supporting documents in the next step.

Click Add Attachments.

You have the option to either Drag and Drop a file here or to Browse your computer to locate the file you would like to attach.

Once the file has been added, click *OK*.

| Attachment Limit: 3 Files<br>Total Size: 0.0 MB of 5 MB li | Add Attachments         | Size        | Limit per file: 2MB (MegaBytes) | Total Size | Limit: SMB (MegaBytes) |  |
|--|-------------------------|-------------|---------------------------------|------------|------------------------|--|
| Attachments  | File Size (In KB)       | Description | Attached By                     |            | Date Attached          |  |
|  |                         |             | No matching data was found.     |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
| Attach A File  |                         |             |                                 | ×          |                        |  |
|  |                         |             |                                 |            |                        |  |
| Drag and Dro   | op                      |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         | Files       | Description                     |            |                        |  |
|  | ~~                      |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
| Browser does   | not support Drag and Dr | op          |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
| Or, Select Fi  | les Here                |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
| D scription  |                         |             |                                 |            |                        |  |
| File   | Browse                  |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |
|  |                         |             |                                 |            |                        |  |

You are then taken to the Comments section.

Note: If the prior authorization requires clinical information and the physician's office will be sending the information to CareFirst, please indicate this in the Comments section. Please also provide the contact information (name and phone number) of the person in the physician's office who will be sending in the clinical information.

#### Comments

Please Enter Comments. To check spelling, click kon. While in spell check mode, unable to edit sentence. Please select icon to disable spell check Spoke with Sally at Dr. ABC's office on 11/152017. She is going to fax required information (lab report) to <u>Catefinst</u>. Sally can be reached at 410-555-5555 or stest@email.com

ABÇ

Important Note: The comment section is also where you can include any additional procedure or diagnosis codes.

You will enter your Contact Information and click Next.

Note: Your information is stored from session to session. An email address is not required but it is recommended.

| Contact Information Please enter the contact for this Authorization. We will email/call the below with questions and status in regard to this request. |                 |                |                         |  |  |
|--|-----------------|----------------|-------------------------|--|--|
| Contact Name:*   | Sally Smith     | Phone Number:* | 410 . 777 . 1231 x 1234 |  |  |
|  |                 |                | ex. 000-000-0000 x 0000 |  |  |
| E-mail Address:  | Test@gmail.com  | Fax Number:    | 000 _ 000 _ 0000        |  |  |
|  | ex. abc@xyz.com |                | ex. 000-000-0000        |  |  |
| Back Not   |                 |                |                         |  |  |
|  |                 |                |                         |  |  |

Review the prior authorization and then click Submit.

Once you submit it, the outpatient notification will be assigned a number.

| ty WorkList | Draft 🛞                    |                             |               |      |  |
|-------------|----------------------------|-----------------------------|---------------|------|--|
| Select a N  | lember 🍃 🖌 Enter Request D | tails 🔷 🗸 Complete Question | Review Reques | at 🔪 |  |
|             |                            |                             |               |      |  |
|             |                            |                             |               |      |  |
|             |                            |                             |               |      |  |
|             |                            | Back 🧧                      | Submit        |      |  |

Finalized requests are reflected as such on the roster as soon as they are finalized.

After a request is in a finalized state, an email is generated overnight to the requestor. This is why we encourage you to enter your email address in the contact information section. Subject: Your CareFirst Pre-Auth/Notification Requests Are Now Complete

Dear <Contact Name>,

The following Request(s) have been completed and are ready for your review.

| Γ | Request ID        | Request Type              |
|---|-------------------|---------------------------|
| Γ | <authid></authid> | Inpatient Notification    |
| Γ | <authid></authid> | Inpatient Notification    |
| Γ | <authid></authid> | Medical Pre-Authorization |
| Γ | <authid></authid> | Medical Pre Authorization |

To review your requests:

- Log into <u>CareFirst Provider Portal</u>.
- Click the "Pre-Auth/Notification" tab at the top of the screen.
- Navigate to the request(s) noted above, by clicking on the <"Pre-Authorizations" / "Inpatient Notifications"> sub-tab.

Thank you for your assistance.

This email address is used for notifications only. Please do not respond to this email as this mailbox is not monitored.

You can review the prior authorization by clicking on the assigned request number.

The roster allows you to filter each column by clicking the dropdown arrow. This will assist in pinpointing the information you would like to view.

| r Auth/Notifications ( | •       | Search Add Search Add Search Testing states |   |                                      |                          |                  |  |
|------------------------|---------|---|---|--------------------------------------|--------------------------|------------------|--|
| NLIST View my Tax ID   |         |   |   |                                      |                          |                  |  |
| PR: ALL                |         |   | Trint Date  |                                      |                          |                  |  |
| - 1 m                  |         | + h ber information                         | Procedure Code                                      |                                      | C Verge (End Re Nat Date | $\mathbf{\cdot}$ |  |
| eved                   | desi (  | DIAME, PRISTNAME                            | STERS PSYCHOTHERNPY COMPLEX INTERNA                 |                                      |                          | Cox.             |  |
| Approved               | Medical | LASTILIAME, PIRSTILIAME<br>10/20/1992       | 37215 TOAT IV STENT ORV ORTD ART EMBOLIC<br>PROTECU | FELA HISTRICALC PERSONALITY DISORDER | 205/19                   | / 64             |  |
|                        |         |   |   |                                      |                          |                  |  |
|                        |         |   |   |                                      |                          |                  |  |
|                        |         |   |   |                                      |                          |                  |  |
|                        |         |   |   |                                      |                          |                  |  |
|                        |         |   |   |                                      |                          |                  |  |
|                        |         |   |   |                                      |                          |                  |  |
|                        |         |   |   |                                      |                          |                  |  |

#### **Red Flag Indicator**

A red flag indicates an incomplete request. Review the authorization request by clicking on the *Assigned ID Number*. You will be provided information regarding any action that needs to be taken.

|               | -                              |         |                     |   |                                       |                  |                |                |   |   |
|---------------|--------------------------------|---------|---------------------|---|---------------------------------------|------------------|----------------|----------------|---|---|
| uth Type: ALL | ¥ štatas                       | • Type  | Member information  | Procedure Code                          | ▼ Diagnosis Code                      | Admission (Start | Discharge (End | - Request Date |   |   |
| -             | Pending- Additionalinformation | Medical | LASTNAME, FIRSTNAME | 98785 PSYCHOTHERRPY COMPLEX INTERACTIVE | FIALD OTHER GENEER IDENTITY DISORDERS | Cont             | (1417)         | 20979          | 1 | E |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |
|               |                                |         |                     |   |                                       |                  |                |                |   |   |

#### **Search Capabilities**

You can search by entering information in the search field (member name, member number or authorization number), or you can click on *Advanced Search* for additional search capabilities.

Enter any of the desired search criteria and click *Search*.

| Prior Auth/Notifications 1  | Search<br>Advanced Search   Check Genetic Testing status |
|---|--|
|   |  |
| My WorkList Search 😈  |  |
| Advanced Search   |  |
| Please enter search criteria :  |  |
| Prior Authorization/ Inpatient Notification:  |  |
| Type: ALL   Status: ALL   Request ID: Alt Request ID:                                       | Requestor:   |
| Request Date: Select One •  |  |
| Member information:<br>Enroliment Source System: ALL •                                      |  |
| Member ID: Date of Birth: 🗰 Last Name: First I  | Name:  |
| Provider Information:<br>Tax ID: Provider NPI# Provider Name Provider Name Practitioner Na  | ame:   |
| Facility Information:           Tex.ID:         Facility ID           Facility Information: |  |
| Reset   |  |
|   |  |

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc., and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross<sup>®</sup> and Blue Shield<sup>®</sup> and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.