Utilization Management Request for Authorization Form

CareFirst Family of health care plans

INSTRUCTIONS

Please complete all fields and attach clinical documentation to support the medical necessity of the service(s) requested. Incomplete information may delay processing of your request. Request review timelines vary and some may take up to 15 days. Review timelines are based on applicable NCQA, state and federal requirements. For artificial insemination (AI) or in-vitro fertilization (IVF), please use the Infertility Pre-Treatment Form. For outpatient rehabilitation please use the Outpatient Pre-Treatment Authorization Program Form. For services that do not require prior nurse review, use the Precertification Request for Authorization of Services form and fax to 410-781-7661, or call Precertification at 1-866-PRE-AUTH (773-2884), option 1.

Participating Providers: To check the status of the authorization, visit CareFirst Direct at **carefirst.com**.

For services that require prior elevated nurse/medical review only.

For services that require nurse review, fax this form to the appropriate pre-service review number below	
Inpatient Services	410-720-3058
Outpatient Services (for BlueChoice HMO level benefits)	410-720-3060
Transplants	410-720-3061
Bariatric Surgery	410-720-3062
Orthognathic Surgery	410-720-3063
Outpatient services for Federal Employee Program (FEP) (Member number starts with single letter "R")	410-720-5322
Post-Acute Care	410-505-2588
Outpatient Behavioral Health	443-753-2333
Applied Behavior Analysis	443-753-2330
Outpatient prior authorization for FEP members is limited to surgery for morbid obesity, IMRT, accidental injury to the jaws, cheeks, lips, roof or floor of the mouth or surgery to correct a congenital anomaly. For prior authorization of services related to life- threatening illness, please contact FEP provider services at 1-800-854-5256 or 202-488-4900.	

RENDERING PROVIDER INFORMATION

Provider's Name			Date (mm/dd/yy)
Phone Number	Fax Number	Provider ID and NPI	
Office Contact's Name	Email Address	Phone Number (including extension)	

If services are to be provided by another provider or vendor, please list the full name, address and phone number below. If requesting Out-of-Network services for a BlueChoice member, please submit a letter of medical necessity explaining why services cannot be provided In-Network.

Provider's Name and NPI	Phone Number
Provider's Complete Mailing Address	

MEMBER/PATIENT INFORMATION

Member Name	Member Number	DOB (mm/dd/yy)

TREATMENT INFORMATION

Date(s) of service or admit date. If service involves multiple visits over a period of time, please specify number of visits and date span requested.

Dates of Service/Admit	Number of Visits

Place of Service (check one) ◯ Inpatient ◯ Outpatient Hospital ◯ Office ◯ Patient's Home ◯ LTAC ◯ SNF

Diagnosis and diagnosis code(s) (ICD-10)

Procedure and procedure code(s) (CPT-4 or HCPCS)

If services are part of a clinical trial, please submit a letter of medical necessity signed by the treating physician, the trial protocol identifying the trial phase, IRB number and approving body.

Hospital/Facility full name (Please include full address and phone number below if out-of-state or non-participating facility)

Hospital/Facility full address and phone number (If out-of-state or non-participating)

FOR POST-ACUTE CARE REQUEST

Please complete all fields below and include all current (within past 24-48 hours) PT/OT/ST or pertinent clinical information for the requested service.

Current Location of Member		Requested Level of Care
Date of Admission to Receiving Facility	Attending Physician at Receiving Facility	Attending Physician NPI
Receiving Facility Complete Mailing Address		Receiving Facility NPI