CarePlus HEALTH PLANS

Health Services Prior Authorization Form

Please use this form for nonurgent requests by faxing to the corresponding number at the bottom of the form. Attach supporting medical documentation with your request.

Prior authorization guidance is available at the **CarePlus Health Plans Prior Authorization Lists** website.

For urgent/same-day services, please call the CarePlus utilization management provider line at **866-220-5448**. Monday – Friday, 8 a.m. to 5 p.m., Eastern time. Expedited requests must meet the Centers for Medicare & Medicaid Services (CMS) definition: "The healthcare professional or member believes the standard time frame could seriously jeopardize the enrollee's life, health or ability to regain maximum function."

Submit prior authorization requests to CarePlus Health Plans via **Availity Essentials™**

Request Type ☐ New request ☐ Updated request ☐ Outpatient prior authorization request ☐ Elective inpatient prior authorization request

Date of request: _____ Appointment date/time: _____

Valid for: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 year First Date: _____ Last Date: _____

Primary care physician information

Name: _____ Sender's name: _____

Provider ID no.: _____ Tax ID no.: _____ National Provider Identifier: _____

Phone no.: _____ Fax no.: _____

Treating provider information

Provider name: _____	Facility name: _____
Provider ID no.: _____	Facility ID no.: _____
Tax ID no.: _____	Tax ID no.: _____
National Provider Identifier: _____	National Provider Identifier: _____
Address: _____	Address: _____
Provider phone no.: _____	Provider fax no.: _____

Visits:

☐ Initial
☐ Follow-up
Number of visits requested: ___

Provider participates with the CarePlus network: ☐ Yes ☐ No

Healthcare facility participates with the CarePlus network: ☐ Yes ☐ No

Is request related to an accident? ☐ Yes ☐ No
If yes, please specify:
☐ Automobile ☐ Worker's comp
☐ Other _____

Patient Information

First name: _____ Last name: _____

CarePlus member ID no.: _____ Date of birth: _____ Phone no.: _____

ICD-10 diagnosis code/description*	Procedure code/description*	Quantity

* Required field(s)

The transmitted information is intended only for the person or entity to whom it is addressed and may contain confidential material. If you receive this document in error, please contact the sender and delete or destroy the material/information.

CarePlus Health Plans fax numbers:

Broward and Palm Beach counties: **866-832-2678**

Miami-Dade county: **888-790-9999**

All other counties: **888-634-3521**