CarePlus HEALTH PLANS

# Health Services Preauthorization Form

Submit preauthorization requests to CarePlus Health Plans (CPHP) via **Availity Essentials™** **www.availity.com**

Use this form for non-urgent requests by faxing to the corresponding number at the bottom of the form. Attach supporting medical documentation with your request.

Preauthorization guidance is availab le at **CarePlusHealthPlans.com/PAL**.

For urgent/same-day services, call the CarePlus Utilization Management provider line at **800-201-4305**. Expedited requests must meet the Centers for Medicare & Medicaid Services (CMS) definition: "The healthcare professional or member believes the member's health, life or ability to regain maximum function can be jeopardized if the standard 14 calendar-day timeframe is applied."

**REQUEST TYPE(S)** ☐ New request ☐ Updated request ☐ Outpatient preauthorization request ☐ Elective inpatient preauthorization request

**PART B DRUG REQUEST. If** Part B drug, select one box below:

☐ The drug is billed, dispensed and administered by physician office, infusion clinic or outpatient facility.

☐ The drug is billed and shipped from a retail pharmacy to the physician's office or facility (non-self administered infusible drug). Fax request directly to CPHP Pharmacy at **800-310-9071**.

Date of request: _____ Appointment date/time: _____

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

**PATIENT INFORMATION** First name: _____ Last name: _____

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

**REQUESTING PHYSICIAN/PROVIDER INFORMATION** (Check only PCP or Specialist) ☐ PCP ☐ Specialist

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 CPHP network:** ☐ Yes ☐ No

**Healthcare facility participates with the CPHP network:** ☐ Yes ☐ No

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

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

* required field(s)



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**CarePlus Health Plans fax numbers:**

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

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

All others: **888-634-3521**