



Health Services Preauthorization Form

Submit preauthorization requests to CarePlus Health Plans (CPHP) via [Availity](#) or [Provider Web Services \(PWS\)](#)

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 available at CarePlusHealthPlans.com/PAL.

For urgent/same-day services, call the CarePlus Utilization Management provider line at **1-800-201-4305**. 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 **1-800-310-9071**.

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.: _____ NPI no.: _____

Phone no.: _____ Fax no.: _____

TREATING PROVIDER INFORMATION

Provider name: _____ Facility name: _____

Provider ID no.: _____ Facility ID no.: _____

Tax ID no.: _____ Tax ID no.: _____

NPI no.: _____ NPI no.: _____

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)

The transmitted information is intended only for the person or entity to which it is addressed. It might 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: **1-866-832-2678**

Miami-Dade county: **1-888-790-9999**

All others: **1-888-634-3521**