ambetter of North Carolina Inc.

Biopharmacy Outpatient

Prior Authorization Fax Form

Please fax this completed form to 1-844-536-2412 Date of request_____

☐ Request to modify existing authorization – please include auth number _____

Details on modification (i.e. units or dates to change)_____

To the best of your knowledge, this request is a:

☐ New Request ☐ Continuation Request - approximate date initiated_____

☐ Expedited/Urgent Review Requested - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

_____

Physician Signature

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID* Date of Birth* Member Phone #

Last Name* First Name*

REQUESTING PROVIDER INFORMATION

Requesting NPI* Requesting TIN* Requesting Provider Contact Name

Requesting Provider Name* Specialty Phone* Fax*

SERVICING PROVIDER/FACILITY INFORMATION ☐Same as requesting provider

Servicing NPI* Servicing TIN* Servicing Provider Contact Name

Servicing Provider Name* Specialty Phone* Fax*

AUTHORIZATION REQUEST

Primary Procedure Code* Additional Procedure Code Start Date Diagnosis Code

(CPT/HCPSS) (Modifier) (CPT/HCPSS) (Modifier) MMDDYYY ICD10

Additional Procedure Code Additional Procedure Code End Date

(CPT/HCPSS) (Modifier) (CPT/HCPSS) (Modifier) MMDDYYY

MEDICATION REQUESTED

Medication Name* Dose Per Visit* Frequency* Total Number of Visits*

Rationale for request and pertinent clinical information is required for all prior authorizations and should be attached to this request. Lack of clinical information may result in delayed determination*

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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