Medicare Advantage Outpatient Pre-Treatment Authorization Program (OPAP) Request

CareFirst Medicare Advantage

INSTRUCTIONS

Participating Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at **carefirst.com**. Please print and complete entire form. Fax form to **443-753-2341**.

Check all that apply:

◯ Physical Therapy (PT) ◯ Occupational Therapy (OT) ◯ Speech Therapy (ST)

CASE INFORMATION

Patient Name (Last, First)		Subscriber Member ID#	
Date of Birth (mm/dd/yyyy) / /	Gender ◯ Male ◯ Female	Number of Visits	Date of Service (mm/dd/yyyy) From / / to / /
Diagnosis Code(s) (ICD-10) Primary		Secondary	

PT/OT/ST RENDERING PROVIDER INFORMATION

Rendering Practitioner		Medicare Advantage Regional Provider ID # (Tax ID # if non-participating)	
Office/Facility Name		Practitioner's Address	
City	State	Zip Code	Treatment Setting ◯ Office ◯ Outpatient Facility

PT/OT/ST REFERRING PROVIDER INFORMATION

Referring Practitioner		Medicare Advantage Regional Provider ID # (Tax ID # if non-participating)	
Office/Facility Name		Practitioner's Address	
City	State	Zip Code	Treatment Setting ◯ Office ◯ Outpatient Facility

CONTACT INFORMATION

Office Name	Office Telephone # & Extension (including area code)
Email Address	Tax ID #
Office Fax #	

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

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 # 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)

AUTHORIZATION EXTENSION (IF APPLICABLE)

Previous Authorization #	Action Requested ◯ Extend End Date ◯ Add Visits

Additional Comments

DISCLAIMER

The above approval is based on the number of visits recommended for the diagnosis indicated. If additional visits are required, please complete and submit a separate authorization form indicating measurable short-term and long-term goals for the member.

Prior to rendering the authorized service, the health care practitioner must verify the member's eligibility and benefits with CareFirst (see page 2 for instructions). If the patient's benefits are not covered on the date the authorized service is delivered, reimbursement will not be provided.

FOR CAREFIRST USE ONLY

Visit(s) Authorized _____

◯ Physical Therapy (PT) ◯ Speech Therapy (ST) ◯ Occupational Therapy (OT)

OPAP Authorization # _____ ◯ No Preauthorization Required

OPAP Comments

IMPORTANT INFORMATION FOR COMPLETING REQUEST FORMS

1. Participating Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at **carefirst.com**.
2. General Instructions
   - Type or print legibly and complete the form in its entirety. Note N/A in blocks that are not applicable.
   - The number of visits and the range for dates of service must agree with those indicated on the claim form. (For example the number of visits cannot be overstated. A visit must not occur outside the approved range for dates of service.) If the claim does not agree with the authorization, claims processing may be delayed and/or the claim may be denied.
   - To order additional forms, please call 410-998-4667. Use your Provider ID number to request the form number noted at the bottom of the first page.
3. Fax completed forms to 443-753-2341 within five days from initial evaluation. Delays may cause a denial or reduction in claims payment. Please do not send additional pages unless requested. Once processed, your OPAP authorization will be faxed back to you. Prior authorization is not required for the first 12 visits.

Be sure to check the patient's eligibility and benefits. Note Authorization is subject to medical necessity. Providers should be familiar with our medical policies as they pertain to Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST). Medical policies are available on the "Programs/Services" at **carefirst.com**.