Medicare Advantage Prior Authorization Form—Utilization Management

INSTRUCTIONS
Please complete all fields and attach clinical documentation to support the medical necessity of the service(s) requested Incomplete information may delay processing of your request. Participating Providers: To check the status of the authorization, visit CareFirst Direct at **carefirst.com**.

Fax this form to the appropriate pre-service review number below	
Inpatient Services HMO/PPO	443-753-2341
Outpatient Services HMO/PPO	443-753-2342
Behavioral Health HMO/PPO	443-753-2347
Inpatient/Outpatient DSNP Only	833-915-3865

RENDERING PROVIDER INFORMATION		
Provider's Name		Date (mm/dd/yy)
Phone #	Fax #	Provider ID/Tax ID*
Office Contact's Name	Email Address	Phone # (including extension)
If services are to be provided by another provider or vendor, please list the full name, address and phone number below.		
Provider's Name		Phone #
Provider's Address		

REFERRING PROVIDER INFORMATION		
Provider's Name		Date (mm/dd/yy)
Phone #	Fax #	Provider ID/Tax ID*
Office Contact's Name	Email Address	Phone # (including extension)
If services are to be provided by another provider or vendor, please list the full name, address and phone number below.		
Provider's Name		Phone #
Provider's Address		

MEMBER/PATIENT INFORMATION		
Member Name	Member #	DOB (mm/dd/yy)

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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)	

*Tax ID if non-participating