# Standardized Prior Authorization Request Form

If submitting as an expedited request, please review the statement and criteria below and attach the required justification.

**Expedited Request:** ☐ *(by checking this box I certify that this request meets the below criteria for being Expedited and I will supply justification)*

**Criteria for Expedited:** Waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

***Justification for Expedited:**
(Attach pages if add'tl space is needed)

| **Health Plan:** | **Health Plan Fax #:** | ***Date Form Completed and Faxed:** |
|---|---|---|
| Commonwealth Care Alliance | 855-341-0720 | |

## Service Type Requiring Authorization (*Check all that apply*)

**Inpatient Care/Observation**
- ☐ Acute Medical/Surgical
- ☐ Acute Rehab
- ☐ Long Term Acute Care
- ☐ Observation
- ☐ Skilled Nursing Facility

**Ambulatory/Outpatient Services**
- ☐ Genetic Testing
- ☐ Infusion
- ☐ Medication
- ☐ Oral Surgery
- ☐ Surgery/Procedure (SDC)

**Outpatient Therapy**
- ☐ Acupuncture
- ☐ Behavioral Therapy
- ☐ Chiropractic
- ☐ Massage Therapy
- ☐ OT
- ☐ PT
- ☐ Speech

**Radiology**
- ☐ CT ☐ MRI ☐ TEE
- ☐ CTA ☐ MUGA ☐ TTE
- ☐ MPI ☐ PET
- ☐ MRA ☐ Stress Echo

**Durable Medical Equipment**
- ☐ Orthotics & Prosthetics
- ☐ Personal Emergency Response System (PERS)
- ☐ Oxygen
- ☐ Purchase
- ☐ Rental

**Home Health**
- ☐ Skilled Nursing ☐ MSW
- ☐ PT ☐ HHA
- ☐ OT ☐ Infusion
- ☐ ST

**Long Term Support Services**
- ☐ Adult Day Health - Level 1 ☐ Homemaker/Chore
- ☐ Adult Day Health - Level 2 ☐ Home Delivered Meals
- ☐ Adult Foster Care ☐ Personal Care (Agency)
- ☐ Day Services ☐ Personal Care Attendant

**Transportation**
- ☐ Transportation Services

**Behavioral Health**
- ☐ Residential Rehabilitation Services (ASAM 3.1)
- ☐ Partial Hospitalization Services (ASAM 2.5)
- ☐ Clinical Stabilization Services (ASAM 3.5)
- ☐ Behavioral Health/Acute Inpatient
- ☐ Community Crisis Stabilization
- ☐ Community Service Program
- ☐ Recovery Support Navigator

**Other - please specify:**

## Provider Information (**Denotes required field*)

| ***Requesting Provider Name:** | ***NPI Number:** | **Tax ID:** | ***Phone:** | ***Fax:** |
|---|---|---|---|---|
| ***Servicing Provider Name:** | ***NPI Number:** | ***Tax ID:** | ***Phone:** | ***Fax:** |
| ***Servicing Facility Name:** | ***NPI Number:** | ***Tax ID:** | ***Phone:** | ***Fax:** |

| ***Contact Person:** | ***Phone:** | ***Fax:** | ***Email:** |
|---|---|---|---|

## Member Information (**Denotes required field*)

| ***Patient Name:** | **Gender:** Male ☐ Female ☐ Other ☐ | ***Date of Birth (DOB):** |
|---|---|---|

| ***CCA ID#:** | ***MassHealth ID #:** | ***Medicare Beneficiary Identifier (MBI):** |
|---|---|---|

***Address:**
***Street Address*** ***Apt #*** ***City*** ***State*** ***Zip***

**Phone:**

## Diagnosis/Planned Procedure Information (**Denotes required field*)

***Principal Diagnosis Description:**

***Secondary Diagnosis Description:**

| ***Service Description** | ***Code (CPT/HCPCS/REV)** | ***Frequency[1]** | ***Total Units** | ***Unit Type[2]** | ***Start Date** | ***End Date** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

☐ *By checking this box, I confirm that I am attaching supporting clinical documents with this Prior Authorization Request*

[1] Frequency includes per week, per month, etc.

[2] Unit Types include: Units, Visits, Days, Hours

# STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM REFERENCE GUIDE

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For complete details on Prior Authorization requirements, please reference the Provider Manual available on the CCA website:

**https://www.commonwealthcarealliance.org/ma/providers/provider-manual-home/**

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**What is the purpose of the form?**

This form is intended to assist providers by streamlining the data submission process for selected services that require prior authorization. It is important to note that an eligibility and benefits inquiry should be completed first to confirm eligibility, verify coverage, and determine whether or not prior authorization is required by the member's plan.

**Who should use this form?**

If you are a provider currently submitting prior authorizations through an electronic transaction, please continue to do so.

The standardized prior authorization form is intended to be used to submit prior authorization requests by Fax. Requesting providers should attach all pertinent medical documentation to support the request and submit to CCA for review.

*The Prior Authorization Request Form is for use with the following service types:*

| Services | Definition *(includes but is not limited to the following examples)* |
|---|---|
| **Ambulatory/Outpatient Services** | Medical services provided to a member in an outpatient setting: hospital outpatient departments, hospital licensed health centers, or other hospital satellite clinics; physicians' offices; nurse practitioners' offices; freestanding ambulatory surgery centers; day treatment centers; surgical procedures. |
| **Inpatient Care/Observation** | Inpatient services are medical services provided to a member admitted to an acute inpatient hospital, including long term acute care, acute rehab, skilled nursing facility, and planned surgical procedures. This category also includes medical observation. |
| **Outpatient Therapy** | Occupational, physical, pulmonary or cardiac, and speech therapy services, including diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, rehabilitate, or prevent worsening functions that affect daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. |
| **Radiology** | High-end radiology services including but not limited to: CT, CTA, MPI, MRA, MRI, MUGA, PET, Stress Echos, TEE, and TTE |
| **Durable Medical Equipment (DME)** | Equipment used to fulfill a medical purpose and enable mobility. Can be rented or purchased and can include wheelchairs, walkers, canes, med/surg supplies, renal supplies and prosthetic devices. |
| **Home Health** | Skilled Nursing; Home Physical Therapy, Occupational Therapy, Speech Therapy, and MSW; home health aide; home infusions |
| **Long Term Support Services (LTSS)** | Including but not limited to: Adult Day Health; Adult Foster Care; Day Services; Homemaker/Chore Services; Home Delivered Meals; Personal Care (Agency); Personal Care Attendant |

## Defining Data Elements

| | |
|---|---|
| **Provider Information** | • The requesting provider is the physician and the servicing provider can be the same physician as the requesting provider or the facility where the service will be provided.<br>• The contact person is the person who is filling out the form. |
| **Diagnosis & Service Codes** | • CPT/HCPCS/REV Codes and descriptions are required in order for a request to be processed.<br>• ICD-10 Codes are required for the diagnosis relevant to the requested services. |
| **Other Information** | • Any supporting clinical documentation should be submitted in addition to this form for prior authorization approval.<br>• For services not listed, please refer to plan specific medical policies for prior authoriza-tion requirements.<br>• Some services may require physician signature and should be submitted with the sup-porting clinical documentation. |