UM Department Phone #: 844-824-8653

UM Department Fax #: 888-522-6740

PRIOR AUTHORIZATION FORM

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-844-243-5175).

PLEASE COMPLETE ALL SECTIONS IN THEIR ENTIRETY AND ATTACH ANY ADDITIONAL CORROBORATING DETAIL TO SUPPORT THIS REQUEST.

PLEASE NOTE: ALL INCOMPLETE FORMS WILL BE RETURNED AND WILL NOT BE PROCESSED.

Requestor's Contact Name:	Requestor's Contact #:	
Patient Information:		
*Name:	*Enrollee ID:	
*Date of Birth:	*Phone #:	
Provider Information:		
Requesting Provider	*Participation Status: ☐ Par ☐ Non-Par	
*Name:	*If non-par, please provide rationale for why the patient needs to use OON provider:*	
*Phone:		
*Address:		
*NPI:		
TIN:		
*Fax:		
*Email:		
*Submission Date:		
Rendering Provider	☐ Same as the Requesting Provider	
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Facility	☐ N/A	
*Name:	*NPI:	TIN:
*Phone:	*Fax:	
*Address:		
Request for extension to existing authorization number:		
Procedure Information:		
***ICD 10** Primary Diagnosis:	Diagnosis Description:	
***CPT/HCPC** Code & Description *(Covered product or service being requested. Include Unit of Measure / Frequency):*		
***Date(s)** of Service:	**# of Units** or Visits:	
***Place** of Service:	☐ Outpatient (19, 22, 24) ☐ Inpatient (21) ☐ Office (11) ☐ Other _____	
***Type** of Service:	☐ Surgical ☐ Medical ☐ DME ☐ Therapy ☐ Diagnostic ☐ Home Health ☐ Hospice ☐ Dental ☐ Nutrition ☐ Transportation	

PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.
INCOMPLETE INFORMATION MAY DELAY THE PROCESS.
Always verify eligibility, benefits, and prior authorization requirements.

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

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient and use, distribute, or coping is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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Medically Necessary Information (in accordance with the Florida Medicaid definition under 59G.1.010):
If this is an EXPEDITED REQUEST, please detail how this request meets the AHCA definition for it to be expedited. If this does not meet AHCA's definition, it will be converted into a standard review. ☐ THIS IS NOT AN EXPEDITED REQUEST.
Why is the covered product(s) or service(s) being requested?

Pertinent Medical History:
This section is for the history of symptoms related to the diagnosis and reason for the request for the product or service. All pertinent positives should be included in this section. Hospitalizations or procedures related to the diagnosis may be stated in this section. If you have tried past treatment options that have failed, then that should also be said here. It is important to note here that unrelated medical history should be avoided here. The last thing you want is information that has nothing to do with the reason that this covered service/treatment needs to be approved. Putting more extraneous information into the documentation takes away from the credibility of the request for clinical documentation. Less is more in your documentation.

Supporting Guideline or Literature:
Please include the pertinent clinical guideline being applied to the request for a covered service or any information that would support the patient's need for the treatment should be added. This would be including any other publications supporting the letter of medical necessity, as well as any lab or test results. Providing lab or radiology results gives hard evidence of the severity of the medical condition.

Medically Necessary Qualification:
Florida Medicaid Medical Necessity is defined as a health care covered service declared by the Agency for Health Care Administration cites that a physician, exercising prudent clinical judgment, would provide to a patient. To qualify, the service must meet **ALL THREE** base elements: **1.** ☐ Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; **2.** ☐ Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; **3.** ☐ Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider; **And one of the following:** **A.** ☐ Enable the enrollee to maintain or regain functional capacity; or **B.** ☐ Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice. **PLEASE NOTE:** Clinical documentation that fails to meet all three elements of the Florida Medicaid definition of medical necessity will be DENIED coverage.