

**FAX COMPLETED FORM WITH SUPPORTING MEDICAL DOCUMENTATION TO:
 443-552-7407 or 443-552-7408**

SECTION 1 - MEMBER INFORMATION			
First Name:	Last Name:	Date of Birth:	Medicaid#
SECTION 2 – HEALTHCARE PROVIDER INFORMATION			
Referring Provider Name:		Provider’s Specialty:	
Office Phone #:		Referring Provider Fax #:	
Servicing Provider Name:		Servicing Provider NPI #:	
Office Phone #:		Servicing Provider Fax #:	
Vendor/Facility Name & Address:		Vendor/Facility NPI:	
DME Request Services under \$500 on the Medicaid Fee Schedule do not require authorization.		Inpatient Request	Outpatient Request
SECTION 3 – SERVICE INFORMATION			
*CPT codes are used to determine the type of services requested. Authorization of these services assumes that you will bill with codes billable under the current Medicaid Fee Schedule. Please contact your Provider Relations representative if you have any questions.			
Diagnosis Code(s)		Diagnosis Code Description(s)	
CPT/HCPCS Code(s)		CPT/HCPCS Code Description(s)	
Admit Date/Scheduled Date of Service:			
SECTION 4 – ADDITIONAL INFORMATION			
NOTE: This request must be accompanied by a physician’s order and/or all other pertinent clinical documentation for appropriate evaluation. Additional documentation may include, but is not limited to: <ul style="list-style-type: none"> - Physicians’ Orders - Progress Notes - Clinical Summary - Diagnostic Test Results - Prior Treatments - Discharge Information 			
For DME:		Physician’s Order Attached Certificate of Medical Necessity (CMN) Attached	
SECTION 5 – APPROVAL INFORMATION <i>(For CareFirst CHPMD Use Only)</i>			
Authorization #:		Approval Date Range: —	
Approval Date:		Reviewer/Approver:	
SECTION 6 – REQUESTOR INFORMATION			
Contact Name:			
Callback Phone #:		Callback Fax #:	
Date of Request:			
SECTION 7 – URGENT REQUEST			
Could the member’s health be harmed by waiting 48 hours for a decision on this request? Yes, then please call 1-800-730-8543 for expedited review. No			

If you need to speak to a Utilization Management Representative, call 1-800-730-8543 Option “8”.
SERVICES ARE NOT CONSIDERED AUTHORIZED UNTIL CAREFIRST BLUECROSS BLUESHIELD COMMUNITY HEALTH PLAN MARYLAND ISSUES AN APPROVAL. This authorization does not guarantee payment of claim.
All authorizations are subject to eligibility requirements and benefit plan limitations.

CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.