CareFirst Community Health Plan Maryland

MEDICAL INJECTION PREAUTHORIZATION REQUEST FORM

FAX COMPLETED FORM WITH SUPPORTING MEDICAL DOCUMENTATION TO: 844-329-0865

SECTION 1 - MEMBER INFORMATION

First Name:	Last Name:	Date of Birth:	Medicaid#

SECTION 2 – HEALTHCARE PROVIDER INFORMATION

Referring Provider Name: **Office Phone #:**	**Provider's Specialty:** **Referring Provider Fax #:**
Servicing Provider Name: **Office Phone #:**	**Servicing Provider NPI #:** **Servicing Provider Fax #:**
Vendor/Facility Name & Address:	**Vendor/Facility NPI:**
☐ **Outpatient Request**	☐ **Inpatient 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)	Dosage/ Number of Units	Frequency/Total number of treatments

Scheduled Date of Service: **(3 month approval intervals)**	**Expected End Date of Service:**

SECTION 4 – SITE OF CARE ADMINISTRATION

☐ **Hospital Infusion**	☐ **Outpatient Infusion**	☐ **Home Infusion**

Rationale for Hospital Infusion:

SECTION 5 – 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:

- Physicians' Orders
- Progress Notes
- Clinical Summary
- Diagnostic Test Results
- Prior Treatments
- Discharge Information

SECTION 6 – APPROVAL INFORMATION *(For Health Plan Use Only)*

Authorization #:	**Approval Date Range:** —

Approval Date:	Reviewer/Approver:

SECTION 7 – REQUESTOR INFORMATION	
Contact Name:	
Callback Phone #:	**Callback Fax #:**
Date of Request:	

SECTION 8 – URGENT REQUEST

☐ **Yes.** *Please call 1-800-730-8543 for an expedited review. Expedited reviews may take up to 72 hours.

☐ **No.** Non-urgent reviews may take up to 14 calendar days.

Please plan accordingly. We will process your request as soon as possible after all relevant medical information is received. Delays will occur if relevant medication information is not provided.

If you need to speak to a Utilization Management Representative, **call 1-800-730-8543 Option "1".**

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.