Capital Health PLAN
An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form for Medical Procedures, Courses of Treatment, or Prescription Drug Benefits

All of the applicable information and documentation is required. Incomplete forms will be returned for additional information.

1. PRIORITY:

☐	a. Standard	
☐	b. Date of Service	Services scheduled for this date:
☐	c. Urgent	Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the member

2. PATIENT INFORMATION:

a. Name (First):	b. Last:	c. MI:	d. DOB(mm/dd/yyyy):
e. Gender: ☐ Male ☐ Female	f. Height:	g. Weight:	
h. Address:	i. City, State, Zip:	j. Phone:	
k. Health Plan ID #:	l. Group #:		

3. ORDERING PHYSICIAN/CLINIC INFORMATION:

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact Name:
e. Clinic Name:		f. Clinic Address:	
g. City, State, Zip:		h. Phone:	i. Fax or email:

4. RENDERING PHYSICIAN/CLINIC/FACILITY/PHARMACY INFORMATION: ☐ Check if same as 3.

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact Name:
e. Physician/Clinic/Facility/Pharmacy Name:		f. Address:	
g. City, State, Zip:		h. Phone:	i. Fax or email:

5. REQUESTED MEDICAL PROCEDURE/COURSE OF TREATMENT/DEVICE INFORMATION:

a. Service Type:
b. Setting/CMS POS Code: Outpatient ☐ Inpatient ☐ Home ☐ Office ☐ *Other ☐
c. *Please specify if other:

6. HCPCS/CPT/CDT CODES

a. Latest ICD Code	b. HCPCS/CPT/CDT Code	c. Code Description	d. Medical Reason

Other Clinical Information – Include/attach clinical/office notes, laboratory information, imaging reports, and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.

69O-161.011, OIR-B2-2180 New 12/16
Capital Health Plan, P.O. Box 15349, Tallahassee, FL, 32317

Medication Management (*Medications Obtained Through the Medical Benefit*): Fax: 850-523-7370

Utilization Management (*Medical Services/Procedures/Items*): Fax: 850-383-3310

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7. OTHER SERVICES (SEE INSTRUCTIONS):

a. Type of Service:	b. Name of Therapy/Agency:	
c. Units/Volume/Visits Requested:	d. Frequency/Length of Time Needed:	e. Initial ☐ Extension ☐ Previous Authorization #:
f. Additional Comments:		

8. PRESCRIPTION DRUG:

a. Diagnosis name and code:			
b. Medication Requested	c. Strength	d. Dosing Schedule (including length of therapy)	e. Quantity Per Month or Quantity Limits
f. Is the patient currently treated with requested medication(s): ☐ Yes ☐ No If yes, When was treatment with the requested medication started?			
g. Explain the medical reasons for the requested medications, including an explanation for selecting these medications over alternatives:			
h. List any other medications patient will use in combination with requested medication:			

9. PREVIOUS SERVICES/THERAPY (INCLUDING DRUG, DOSE, DURATION, AND REASON FOR DISCONTINUING PREVIOUS THERAPY):

a.	Date Discontinued
b.	Date Discontinued
c.	Date Discontinued

Additional Information – Please attach and submit any progress notes, lab data, discharge summaries, or other guiding documentation to support discontinuation of previous therapy and initiation of therapy with the requested medication along with a copy of the prescription.

10. ATTESTATION

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

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Provider Signature:_____ Date:_____

DO NOT WRITE BELOW THIS LINE: FIELDS TO BE COMPLETED BY PLAN

Authorization #_____ Contact Name: _____