AdventHealth Advantage Plans

Health First Health Plans

Medical Authorization Request Form

Fax medical authorization requests to: 1.855.328.0059
Phone: Toll-Free 1.855.882.6467 /TDD Relay
1.800.955.8771 Visit myAHplan.com

Complete all information in this section

REVIEW TYPE – *Check one*

- ❑ **Standard (≤ 14 days)**
- ❑ **Accommodate scheduling/patient needs** (Date needed: _____/_____/_____)
- ❑ Urgent (≤ 72 hours)
  Provider certifies that the standard review time frame would seriously jeopardize the member's life or health.

  Clinical reason for urgency: _____

  Practitioner signature: _____

==========

DATE OF REQUEST _____/_____/_____

REQUEST TYPE – Check all that apply

- ❑ Initial request ❑ Change to initial request – Auth #: _____
- ❑ Addition to initial request – Auth #: _____
- ❑ Second medical opinion (Provide reason): _____
- ❑ Out-of-network provider request (Provide reason): _____

==========

Member ID#: _____ **DOB:** _____/_____/_____

Member Name (First/Last): _____

Requesting Provider Name (First/Last): _____

Provider Contact Name: _____

Provider Phone: (_____)_____Ext._____ Fax: (_____) _____

Performing/Servicing Provider: ❑ Check if same as Requesting Provider **NPI or TIN** _____

Name (First/Last): _____ Specialty: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Facility/Supplier: ❑ Check if same as Requesting Provider **NPI or TIN** _____

Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Check applicable place of service *AND* complete requested information

Place of Service:

❑ Office (11) ❑ Home (12) ❑ Inpatient Hospital (21) ❑ Outpatient Hospital/Observation (22)

❑ Ambulatory Surgery Center (24) ❑ SNF (31) ❑ Other _____

Requested Dates of Service: From: _____/_____/_____ To: _____/_____/_____

Requested CPT/ HCPCS Code(s)	Requested CPT/ HCPCS Code Description(s)	# Visits/ Days/ Units Requested	ICD Code(s)	Diagnosis (ICD Code) Description(s)
DME: ❑ Bilateral ❑ Right ❑ Left / ❑ Purchase ❑ Rental / ❑ Initial ❑ Subsequent				

AUTHORIZATION DOES NOT GUARANTEE COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT LIMITS OR PROVIDER CONTRACTUAL LIMITS.

CONFIDENTIALITY: The information contained in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this telecopy is strictly prohibited. If you have received this telecopy in error, please immediately notify the sender above and return the original message to us at the address above by the United States Postal Service. Thank you for your cooperation.

AFFIRMATIVE STATEMENT: UM decision-making is based only on appropriateness of care and service and existence of coverage. Health First Health Plans does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

AdventHealth Advantage Plans is administered by Health First Health Plans. Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal. Health First Commercial Plans, Inc. is doing business under the name of AdventHealth Advantage Plans. AdventHealth Advantage Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

36194_MPINFO7466AH(08/19)

Last revised: 6/2019