AdventHealth Advantage Plans

Health First Health Plans

Provider Prior Authorization Form

Fax medical authorization requests to: 1.855.328.0059
Phone: Toll-Free 1.844.522.5278 /TDD Relay 1.800.955.8771
Visit myAHplan.com

COMPLETE ALL INFORMATION

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: ____________________

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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): ____________________

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MEMBER ID#:___________________ **MEMBER NAME (FIRST/LAST):**__________________________________ **DOB:**______________

REQUESTING PROVIDER NAME (FIRST/LAST):____________________

PROVIDER CONTACT NAME:______________________________ 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 below *AND* complete requested information.

COMPLETE APPLICABLE 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.

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AFFIRMATIVE STATEMENT: UM decision-making is based only on appropriateness of care and service and existence of coverage. AdventHealth Advantage 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.

LAST REVISED: 5/2018 – Apply updates to