Print Form Reset Form

Community Care Plan
The Health Plan with a Heart

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

If you have questions about our prior authorization requirements, please call 1-800-424-7897

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

3. ORDERING PHYSICIAN/CLINIC INFORMATION:

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

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

a. Name:	**b. TIN/NPI#:**	**c. Prescriber's Medicaid ID#:**	**d. Specialty:**
e. Contact Name:	**f. Physician/Clinic/Facility/Pharmacy Name:**	**g. Address:**	
h. City, State, Zip:		**i. Phone:**	**j. 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.

Fax or mail completed forms to:

Community Care Plan
c/o Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811, St. Paul, MN 55164-0811

Phone: 1-800-424-7897
Fax: 1-800-424-7913
Website: ccpcares.primetherapeutics.com

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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.

Provider Signature: _____ Date: _____

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

Authorization #: _____ Contact Name: _____

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Instructions for OIR-B2-2180

1. Priority: Only one of the following options should be marked.
    a. Standard should be marked if the prior authorization request is not an urgent request or the medical service has not been scheduled.
    b. Date of Service should be chosen if the requested medical service has been scheduled for a future date. The scheduled date should be written in the corresponding box to the right of the Date of Service label. Note that this is for informational purposes only and that the health insurance issuer is not obligated to provide authorization prior to the scheduled date.
    c. Urgent should be marked if the patient's life may be seriously jeopardized by applying the standard review time frame.
2. Patient Information: All boxes should be completed.
    a. Fill in the patient's first name
    b. Fill in the patient's last name
    c. Fill in the patient's middle initial.
    d. Fill in the patient's date of birth beginning with the two-digit numerical representation for the month, followed by the two-digit numerical representation for the day, followed by the four digit year.
    e. Check the patient's applicable gender.
    f. Fill in the patient's height in inches.
    g. Fill in the patient's weight in pounds.
    h. Fill in the patient's current address if available.
    i. Fill in city, state, and zip code of the patient's address if available.
    j. Fill in the patient's phone number if available.
    k. Fill in the patient's unique health plan identification number.
    l. If available, fill in the patient's group identification number.
3. Ordering Physician or Clinic Information. In this section, complete all of the applicable boxes for the physician who is requesting the medical service.
    a. Fill in the provider's unique tax identification number or national provider identification number.
4. Rendering Physician. In this section, complete all of the applicable boxes for the physician who is being requested to perform or administer the medical service. If the ordering physician is the same as the rendering physician, mark the box next to the title. The section will not need to be completed unless any information differs from section 3.
    a. Fill in the provider's unique tax identification number or national provider identification number.
5. Requested medical Procedure, Course of Treatment, or medical Device information.
    a. In this box, explain with sufficient accuracy the nature of the requested medical service.
    b. Write the Setting or CMS Place of Service Code. Additionally, mark the box to the right of where the requested medical service will be performed or given.
    c. If Other was marked in 5.a., write where the requested medical service or device will be given.

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6. HCPCS/CPT/CDT CODES. In this section you should explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
    a. Enter the most current International Classification of Disease Code used to classify and code the diagnoses, symptom, or procedure applicable to the patient's condition.
    b. Explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
    c. Provide a description of the code used in 6.b.
    d. Provide a medical reason for requesting the medical service.
    e. Other Clinical Information – If necessary attach other relevant guiding documentation to the request. This does not call for the submission of all documents, just those necessary to make a decision on the request. If this is an out of network request, provide an explanation and attach it to the request.
7. This section should be completed in the event the requested medical service does not fall within the other sections. A description of the nature of the medical service requested and corresponding details should be completed to fully convey what is being requested. Examples of other services may include, but are not limited to, rehabilitation services and home health care services.
8. This section should be completed if prescription medication is being requested.
    a. Fill in the diagnosis name and code of the condition the prescription drug will be used to treat.
    b. Detail the medication requested.
    c. Detail the strength of the medication requested.
    d. Detail the dosing schedule of the medication requested, including the length of therapy.
    e. Detail the quantity per month or quantity limit of the medication requested.
    f. Check the appropriate box and explain if necessary.
9. Previous Services or Therapy (Including Drug, Dose, Duration, and Reason for Discontinuing Previous Therapy). This section should be completed if the patient has had previous therapy relating to the medical service being requested. All relevant previous services or therapy should be explained. If there is not enough space, attach another sheet to explain other therapies. If additional guiding documentation is necessary to explain the previous therapy or treatment, that should be attached as well. Include any reason for discontinuing the previous services or therapy.
10. The requesting provider must truthfully certify that all information provided as part of the prior authorization request is true and accurate.

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