Metro Plus Health

PHYSICIAN ADMINISTERED OR INFUSION DRUG PRIOR AUTHORIZATION REQUEST FORM

Please fax this form along with supporting clinical documentation to the appropriate fax number below (corresponding to the service type).

Medicaid/Marketplace Exchange/Essential Plan/CHP/Gold	**Fax 212-908-5178**	**Medicare**	**Fax 212-908-4401**

Authorization/Tracking #:	**E-Power Cert #:** (if applicable)

REQUEST TYPE

☐ **Preauthorization:** Request for approval for coverage of a service or treatment before the service or treatment is performed.

☐ **Retrospective:** Request for approval for coverage for a service or treatment already rendered without prior authorization.

Date(s) of Service: _____

☐ **Standard**
- Preauthorization = 3 business days
- Concurrent = 1 business day
- Retrospective = 30 calendar days

☐ **Expedited:** The expedited review request is subject to denial if there is no documented life-threatening condition or imminent danger to the member's health. If a request to expedite a review is denied, a determination will be made within the standard timeframe. Retrospective reviews are not eligible for expedited review.

MEMBER INFORMATION

Name:	ID#:	Date of Birth:
Street Address:		Phone Number:
ICD-10 Diagnosis Codes(s):		

PROVIDER INFORMATION

Requesting Provider Name:		Requesting Provider NPI:
Street Address:		
Phone Number:	Fax Number:	Contact Name:
Servicing Provider Name:		Servicing Provider TIN/NPI:
Street Address:		
Phone Number:	Fax Number:	Contact Name:

REQUESTED SERVICE INFORMATION

Code	Dose and Frequency	# of Doses	Date of Last Dose Given	Date of Next Scheduled Dose

PLACE OF SERVICE

☐ 11 Office ☐ 19 Off-Campus Outpatient ☐ 22 On Campus - Outpatient

☐ 12 Home ☐ Other _____