AmeriHealth Caritas Florida

PERFORMRX℠

HCPCS/CPT Prior Authorization Request

For other prior authorization forms, visit **www.amerihealthcaritasfl.com**.

To submit requests, please fax completed form to **1-855-829-2871**.
For assistance, please contact PerformRx at **1-855-371-3963**.

Providers are responsible for obtaining authorization for services prior to providing service. Please submit clinical information and orders as needed to support medical necessity of the request. Requests will not be processed if any of the following information is missing: appropriate clinical information, specialist and/or primary care clinical summaries, treating provider, or CPT and ICD-10 codes.

As a reminder, authorization is not a guarantee of payment. Payment is subject to benefit coverage rules, including member eligibility and any contractual limitations in effect at the time of service. Requests should be submitted via fax. For the most up-to-date listing of services requiring prior authorization, visit the Provider Resources page at **www.amerihealthcaritasfl.com**, or call Provider Services at **1-800-617-5727**.

Today's date:	Requested start date of service:
☐ Standard request	AmeriHealth Caritas Florida has seven days to render a decision from date of request, and can extend time frame by an additional seven days.
☐ Expedited	AmeriHealth Caritas Florida has 48 hours to render decision from date of request, and can extend time frame by an additional two business days. Request must include a physician's order stating that waiting for a decision under the standard time frame could endanger the member's life, health, or ability to regain maximum functionality, or would cause serious pain. Requests received without this order will be handled under the standard time frame.

A. Member information

Medicaid ID number:	Member last name:	Member first name:
Date of birth:	Member address:	
ICD-10 codes:	Member phone number:	Gender: ☐ Male ☐ Female

B. Review type

☐ Initial
☐ Cancel
☐ *Changes to date(s) of service/setting
☐ *Other (specify):
☐ *Extension of services
☐ Additional clinical

☐ Discharge planning (services needed for members discharged from inpatient setting such as hospital, skilled nursing facility, etc.)

*Please specify (if applicable, previous authorization number):

Service type: ☐ Non-participating ☐ OB/GYN ☐ Other (please specify):

C. Provider information

Provider name:	Provider address:	Provider phone number:
Provider fax number:	Contact name:	Contact phone number:
Contact fax number:	NPI:	Provider Medicaid ID:
Contact name:	Contact phone number:	Contact fax number:

Treatment setting: ☐ Outpatient ☐ Inpatient ☐ Home ☐ In Office ☐ *Other

*Please specify if other selected: _____

D. HCPCS and CPT codes

HCPCS/CPT	Drug name and strength	Directions and frequency of administration	Number of units	Fills	Dates of service	
					From (mm/dd/yyyy)	Through (mm/dd/yyyy)

☐ Medication to be delivered to physician's office – pharmacy billing

☐ Office reimbursement requested – physician billing

☐ Deliver to patient home – pharmacy

Other clinical information: Include or attach any clinical and office notes, doctor's orders, labs, and imaging reports to support medical necessity. If this is an out-of-network request, please provide an explanation and complete the non-participating provider form.