FAXC

NIAMagellan

Texas National Imaging Associates, Inc.
P.O. Box 2273
Maryland Heights, MO 63043

# PLEASE FAX THIS FORM TO: 1-888-656-6648

Date:

| | |
|---|---|
| **PHYSICIAN:** | |
| **FAX NUMBER:** | |
| **RE:** | Authorization Request |
| **MEMBER ID:** | |
| **PATIENT NAME:** | |
| **HEALTH PLAN:** | USAble Texas |

**INFORMATION REQUIRED FOR CASE REVIEW**

Please **PROVIDE:**

1. All office visit notes or reports, including most recent office visit and specialist notes, since initial visit for the clinical problem
2. Contact information of specialist for whom the physician is ordering the study
3. Diagnostic/laboratory test results or imaging reports, such as ultrasound(s) for the clinical problem, and notes about need for follow-up imaging
4. Information giving reason for the requested study (e.g. copy of imaging order request form, etc)
5. Details of any current or completed treatment

***The ordering physician is responsible for obtaining prior authorizations including the submission of the clinical record if requested. Please respond ASAP with the clinical information outlined above to avoid any delays in patient care.***

**Please include the office phone number for the nurse or clinical staff: ( ) _____**

**If applicable, please include the contact information of the specialist for whom the physician is ordering the study:**
**( ) _____**

All information supplied is considered part of the member's utilization review record with NIA and will be kept strictly confidential **in accordance with HIPAA and/or applicable state law**. For questions, please contact the NIA call center at 1-877-642-0522.

**IF THIS CASE IS CLINICALLY URGENT, PLEASE CALL NIA. FAXES ARE NOT REVIEWED FOR URGENCY.**
TO FACILITATE A TIMELY REVIEW, USE THIS COVERSHEET
**SEND ONLY ONE PATIENT PER FAX: MULTIPLE PATIENTS IN A FAX WILL DELAY REVIEW.**

FAXC

# Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 Texas Department of Insurance

***Please read all instructions below before completing this form.***
*Please send this request to the issuer from whom you are seeking authorization.* ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

**Intended Use:** Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

**Do not use this form to:** 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

**Additional Information and Instructions:**

**Section I – Submission:**
An issuer may have already entered this information on the copy of this form posted on its website.

**Section II – General Information:**
**Urgent reviews:** Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

**Section IV – Provider Information:**
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

**Section VI – Clinical Documentation:**
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

***Note:*** *Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*
***Note:*** *If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

# TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

## SECTION I — SUBMISSION

| Issuer Name: | Phone: | Fax: | Date: |
|---|---|---|---|
| | | | |

## SECTION II — GENERAL INFORMATION

| | | | |
|---|---|---|---|
| Review Type: ☐ Non-Urgent ☐ Urgent | | Clinical Reason for Urgency: | |
| Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment | | Prev. Auth. #: | |

## SECTION III — PATIENT INFORMATION

| Name: | Phone: | DOB: | ☐ Male ☐ Female ☐ Other ☐ Unknown |
|---|---|---|---|
| Subscriber Name (if different): | Member or Medicaid ID #: | Group #: | |

## SECTION IV — PROVIDER INFORMATION

| **Requesting Provider or Facility** | | **Service Provider or Facility** | |
|---|---|---|---|
| Name: | | Name: | |
| NPI #: | Specialty: | NPI #: | Specialty: |
| Phone: | Fax: | Phone: | Fax: |
| Contact Name: | Phone: | Primary Care Provider Name (see instructions): | |
| Requesting Provider's Signature and Date (if required): | | Phone: | Fax: |

## SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

| **Planned Service or Procedure** | **Code** | **Start Date** | **End Date** | **Diagnosis Description (ICD version___)** | **Code** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration:_____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

## SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

***An issuer needing more information may call the requesting provider directly at:*** _____