

MEDICAL MANAGEMENT



PRE-AUTHORIZATION INFORMATION

**FIRST COAST ADVANTAGE
PROVIDER INSERVICE
OCTOBER 3, 4, 5, 2007**

First Coast Advantage Pre-Authorization List

PHONE NUMBER: 244-3539

FAX NUMBER: 244-9744

Pre-Authorization Requirements	Authorization/Notification Requirements
<ul style="list-style-type: none"> • All out of network service (non-par First Coast Advantage Providers) includes diagnostic test, labs, x-rays, MRI, ultrasounds and PET Scans. • All Shands/UF Gainesville services require pre-authorization. • Abortions, Sterilizations, and Hysterectomies • Non-emergency inpatient hospital/observation and acute rehab admissions (includes Behavioral Health and elective surgeries). • Skilled Nursing Facility admissions. • Plastic Surgery evaluations/consultation and surgery (cosmetic/reconstructive procedures) and related care. • Oral surgery (OMFS services) • Outpatient Behavioral Health authorization required for all services. • DME/Medical supplies. <ul style="list-style-type: none"> ○ Customized wheelchairs specially sized and constructed ○ Power wheelchairs and scooters ○ Substantial repairs/parts member owned medical equipment ○ Hospital/specialty beds ○ Augmentative/alternative communication devices ○ Oxygen related equipment and services ○ Ventilator and respiratory equipment ○ Enteral feedings ○ Wound care supplies • Cochlear Implant (Eval & Procedure) • Hyperbaric oxygen therapy • Growth treatment • Obstetrical Care (auth required from OB for professional services, plus notification from hospital). • Home Health Care or Infusion • Dialysis • Orthotics, Prosthetics and Braces • Transplants and related care • Medically Necessary Circumcisions 	<p>Hospital: (Medical & Behavioral)</p> <ul style="list-style-type: none"> • Emergency Room visits within 24 hours or next business day. • Emergency inpatient admissions and observations (within 24 hours or one business day). <hr/> <p>Member may self-refer with no authorization to the following services, but may be limited to the number of visits indicated.</p> <p>Chiropractic: Limit of 10 visits per calendar year.</p> <p>Podiatry: Limit of 4 visits per calendar year.</p> <p>Dermatology: No limit</p> <p>Family Planning: No limit</p>



This authorization satisfies the pre-authorization requirement. It does not guarantee payment.

PLEASE RETURN
FAX TO 244-9744

PRE-AUTHORIZATION FORM

Today's Date: _____ Date Sent: _____
Patient Name: _____ SS #: _____ DOB : _____
Patient Home Phone: _____ Patient Work Phone: _____
Payor/Insurance (Primary): _____ ID #: _____
Payor/Insurance (Secondary): _____ ID #: _____
Primary Care Physician: _____ Office Name: _____
Requesting Physician: _____ Office Name: _____
Office Phone #: _____ Fax # _____ Contact Name/Phone: _____
ICD 9 Code(s) & Descriptions: _____
_____ If Pregnant, LMP: _____ EDC: _____

CPT/HCPC Code(s) & Description(s): _____

Place/Type of Service: Outpatient Office Outpatient Surgery 23 Hr Observation
 DME Inpatient Stay Diagnostic Procedure Home Health

THIS SECTION TO BE COMPLETED BY THE PROVIDER OR CLINICAL STAFF

REFERRING TO: (Complete areas that apply-Attach medical information if available)

A. Specialty Physician/Service: _____ Provider ID #: _____
Specialist Fax: _____ Specialty: _____

B. Reason for Pre-Authorization: _____

C. Brief History; Include Prior Auth and Surgery: Clinicals attached: N Y # of pgs _____

How soon does patient need to be seen? Stat: Appt. First Available: Routine:

Attending Physician Signature: _____ Physician ID #: _____

THIS SECTION IS FOR FCA PRE-AUTHORIZATION DEPT USE ONLY

DOS: _____ New: _____ Update: _____ # of Visits: _____ Total: _____

Auth # _____ Exp. Date: _____

Received Date & Time _____ Approved Date & Time _____ By: _____

**For Billing information, please call Benefit Services: (866) 270-2468
Claims submissions: First Coast Advantage, P. O. Box 3620, Akron, OH 44309-3620**



**REQUEST FOR ADDITIONAL UNITS
BEHAVIORAL HEALTH SERVICES FORM**

Please return by fax to: (904) 244-9740
Attention: Behavioral Health Coordinator
Call (904) 244-9197 or 244-9780 with questions

Please Print Clearly.

Today's Date: _____ Admit Date: _____ Member Name: _____

SS #: _____ DOB: _____ Medicaid Number: _____

Original Authorization Number: _____

Agency/Center: _____ Location: _____

Services to be provided with additional units: (Circle all that apply)

Medication Management Case Management Intensive Case Management

Individual/Family Counseling Group Counseling Psychosocial Rehabilitation

Other _____

Provider Name: _____ **Provider Phone Number:** _____

Clinical Justification for additional units: _____

Please attach a copy of the most recent FARS/CFARS. Current Diagnosis: _____

If member is receiving Psychosocial Rehabilitation, please answer the following in detail:

1. How are the member's needs being met through psych. rehab? _____

2. How often is the member attending and how is this frequency justified? _____

3. Describe the member's progress over the past six months and explain how further services will benefit the member: _____

____ Units Approved Denied Additional information needed

New authorization #: _____

Approved Services: Case Management Intensive Case Management Med. Management

Individual/Family Counseling Group Counseling Psychosocial Rehabilitation

Other Services: _____



NOTIFICATION AND PRE-AUTHORIZATION BEHAVIORAL HEALTH SERVICES FORM

Please return by fax to: (904) 244-9740
Attention: Behavioral Health Coordinator
Call (904) 244-9197 with questions

Please print clearly.

Today's Date: _____ Admit Date: _____ This is a: Notification ___ Pre-Authorization ___

Member Name: _____ SS #: _____ DOB : _____

Medicaid Number : _____ Member Home Phone : _____

Agency/Center: _____ Location : _____

Member is: New to Services ___ Established ___ FARS/CFARS at admission: _____

ICD-9 Code(s) & Descriptions: _____

Services to be Billed (circle all that apply) : Inpatient admission Med Management

Case Management Outpatient Individual/Family Counseling Outpatient Group Counseling

Psychosocial Rehabilitation

Others _____

Provider Name: _____ Provider Phone Number: _____

Provider Name: _____ Provider Phone Number: _____

Provider Name: _____ Provider Phone Number: _____

*For Billing or Claims Submission Information, Please call APEX Benefit Services: (866) 270-2468

THIS SECTION IS TO BE COMPLETED BY BEHAVIORAL HEALTH COORDINATOR

Submitted telephonically _____ Received Date & Time: _____

FACT consumer _____ Case Management Services _____

FARS/CFARS at discharge from services: _____ Rater: _____