

MEDICAL MANAGEMENT



PRE-AUTHORIZATION INFORMATION

FIRST COAST ADVANTAGE
PROVIDER INSERVICE

May 14, 15, 16, 2007



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

PRE-AUTHORIZATION FORM

PLEASE RETURN

FAX TO 904- 244-9744 OR EMAIL TO PRE.AUTHORIZATIONS@JAX.UFL.EDU

Today's Date: _____ New Request: Updated Request:
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: _____
E-mail address for auth response: _____
Contact Phone: _____ Contact Fax: _____
ICD 9 Code(s) & Descriptions: _____
DOS: _____ 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

Pre-authorization In-Service Handouts May 2008

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First Coast Advantage Pre-Authorization List

PHONE NUMBER: 904-244-3539

FAX NUMBER: 904-244-9744

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. • Proton Beam Therapy • 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 • 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). <p style="color: red;">Transportation: Verbal authorization required by Logisticare for transportation of members 60 miles or greater in one direction.</p> <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: Chiropractic patients can have 10 visits without a referral or authorization. Chiropractic visits 11 – 24 require authorization. Chiropractic visit 25 will be denied for benefits exhausted.</p> <p>Podiatry: Podiatry patients can have 4 visits without a referral or authorization. Podiatry visits 5 -24 require authorization. Podiatry visit 25 will be denied for benefits exhausted.</p> <p>Dermatology: No limit</p> <p>Family Planning: No limit</p>



Your FCA Authorization Information

Member:				
DOS/First DOS:				
Referred to Provider:				
No. of Approved Visits:				
Authorization Number:				
Auth Valid Thru/Expiration Date:				
<input type="checkbox"/> Outpt Office	<input type="checkbox"/> Outpt Surgery	<input type="checkbox"/> DME	<input type="checkbox"/> HHC	<input type="checkbox"/> Diag. Proc.
<input type="checkbox"/> 23 Hour Observ	<input type="checkbox"/> Inpatient Stay			

Retrieving ZIX mail from the WEB

When you receive your email Follow the instructions.

Comcast Webmail - Email Message - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Search Favorites

Address <http://mailcenter3.comcast.net/wmc/v/wm/48207F5E0006AB0600005A7E2215551724CFCE97040A0A9C?cmd=Show&no=65> Go Links

Subject: zix mail
Date: Tuesday, May 06, 2008 11:54:56 AM [View Source]

You have a secure message from jay.seely@jax.ufl.edu in the ZixMessage Center.

To view the secure message, [click here](#).

Do not reply to this notification message. This notification message was auto-generated by the sender's security system. To reply to the sender, please go to your secure message by clicking on the link above.

The secure message expires on May 20, 2008 @ 10:54 (CDT).

If you would like to have your secure messages delivered directly to your inbox, find out more about [ZixMail](#).

NOTE: If your mail program does not support active links, you can view your secure message by copying and pasting the text below into the "Address" or "Location" bar of your Internet browser and press "Enter" or click "Go".

<https://zixmessagecenter.com/s/e?m=AB03svr0RbkTqJhggmgsQ4fp&em=seely10%40comcast%2enet>

INBOX: Email 1 of 654 Back to Top Previous Next

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Sign in or create your account if you are a first time user.

ZixMessage Center Password Authorization - Microsoft Internet Explorer

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Address <https://zixmessagecenter.com/s/login?b=zmc&m=ABA3svrORbkTqJhggmgsQ4fp&em=seely10%40comcast%2enet> Go Links >>

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Email Address:

Password: [Forgot your password?](#)

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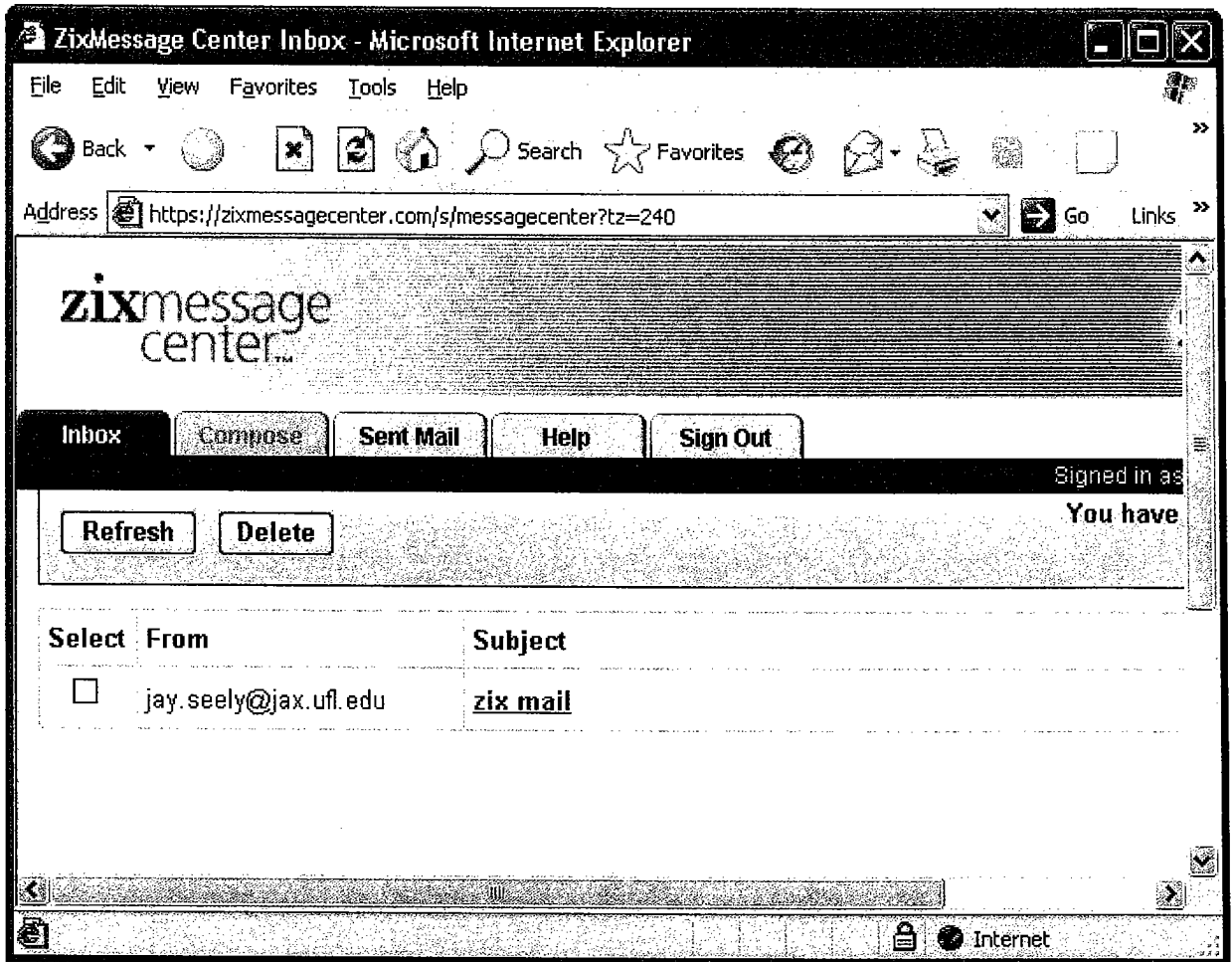
Want to receive your secure messages directly in your inbox? [Learn more about ZixMail.](#)

For Customer Support, email us at support@zixcorp.com.

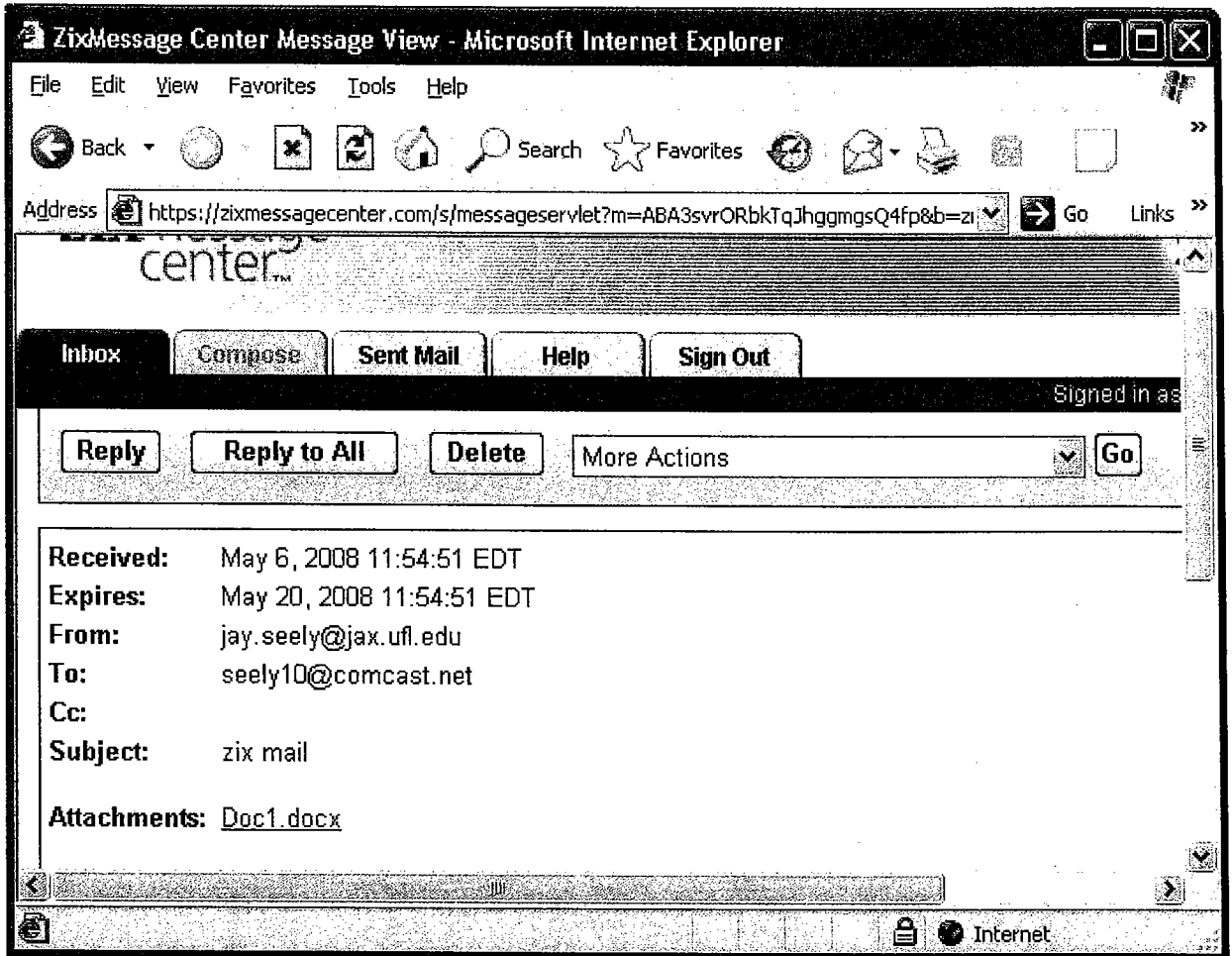
Use of this system is limited to business purposes. Misuse or violation will be handled in accordance with appropriate security policies.

Internet

Select the email and double click zix mail



Your email will open and you can then open and save any attachments.





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

PLEASE RETURN
FAX TO 244-9744

**PRE-AUTHORIZATION FORM FOR
DME REQUIRING PRE- AUTHORIZATION REVIEW AND PRICING**

Today's Date: _____ Date Sent: _____
Member Name: _____ SS #: _____ DOB : _____
Member Home Phone: _____ Member Work Phone: _____
Payor/Insurance (Primary): _____ ID #: _____
Payor/Insurance (Secondary): _____ ID #: _____
Primary Care Physician: _____ Office Name: _____
Requesting DME Provider: _____ Office Name: _____
Office Phone #: _____ Fax # _____ Contact Name/Phone: _____
ICD 9 Code(s) & Descriptions: _____

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

Attach the following documentation:

1. Documentation of medical necessity that is specific per Medicaid policy. Must be signed and dated by an authorized prescriber;
2. Description of the items or services;
3. Name of the manufacturer's model, style, features, attachments, modifications and accessories;
4. Description of the time, skill and equipment to be used;
5. Documentation of any cost incurred, including billing invoices from the manufacturer;
6. If for a non-routine service, a description of the item before the repair;
7. If a repair service, the manufacturer, duration of the warranty, model and serial number and
8. Date and time the item will be made available to the member.

THIS SECTION IS FOR FCA PRE-AUTHORIZATION DEPT USE ONLY

FCA Approved Price: _____
Auth # _____ Exp. Date: _____
Received Date & Time _____ Approved Date & Time _____ By: _____

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Claims submissions: First Coast Advantage, P. O. Box 3620, Akron, OH 44309-3620**