



***** High Priority *****

Service Alert Notification

Subject: FCA Authorization Process for Incomplete or Missing Information

Date: August 3, 2010

First Coast Advantage (FCA) has revised the pre-authorization form due to the large volume of incomplete preauthorization requests received in the FCA Pre-authorization Department. Effective immediately, FCA will no longer process authorization requests that are incomplete.

An Incomplete pre-authorization is defined as any request that does not contain the information needed to process the request.

Examples:

- Missing or incomplete Certificate of Medical Necessity for DME (*Durable Medical Equipment*).
- Missing or incomplete clinical information.
- Missing ICD-9 (*Diagnoses*) and CPT (*Procedure*) codes
- Missing patient demographic information.
- Missing all required information on authorization form
- All lines on authorization form must be completed or N/A (*Not Applicable*) indicated.

Incomplete authorization requests will be handled in the following manner:

- All incomplete authorization request forms will be faxed back to the requesting provider.
- The incomplete authorization **will not** be located in the FCA Webportal.
- The date the incomplete pre-auth request was faxed back to the requesting provider and the information needed to process the request, will be added to the bottom of the preauthorization form. (See attached revised preauthorization form)
- Any incomplete pre-authorization request will be discarded. (No matter how many times it was submitted).
- **It will be the responsibility of the requesting provider to resubmit a new authorization request that includes the missing or incomplete information.**
- All timeframes for completion of an authorization will start when a completed and workable authorization request is received in the FCA Pre-Authorization Department.

Any incomplete authorization currently in the FCA Pre-Authorization Department will not be discarded. However, staff will still be required to resubmit authorization request with the incomplete or missing information.

Effective August 9, 2010, any incomplete authorization request received by FCA Pre-Authorization Department will be discarded. If you have any questions regarding this new process, you can e-mail to the pre-authorization department at pre.authorizations@jax.ufl.edu.



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

E-mail: pre.authorizations@jax.ufl.edu

PRE-AUTHORIZATION FORM

Fax to: 904-244-9744

Hospital / Inpatient Rehab Discharge Requests

Fax to: 904-244-9740

Today's Date: ___/___/___ New Request: [] Updated Request: []
Patient Last Name: _____ First Name: _____ DOB: ___/___/___
Patient Address: _____ City: _____
State: _____ Zip Code: _____ Patient Home Phone: (____) _____ Patient Work Phone: (____) _____
Payor/Insurance (Primary): _____ Insurance ID #: _____
Payor/Insurance (Secondary): _____ Insurance ID #: _____
PCP Last Name: _____ First Name: _____ Office Name: _____
Requesting Physician Last Name: _____ First Name: _____
Office Name: _____ E-mail address: _____
Contact Phone: (____) _____ Contact Fax: (____) _____ ICD 9 Code(s): _____
ICD9 Descriptions: _____
Date of Service: ___/___/___ If Pregnant-LMP: ___/___/___ EDC: ___/___/___ CPT/HCPC Code(s) _____
CPT/HCPC Description(s): _____

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

NOTE: If Requesting Wheelchairs (Power); Beds; etc. Use DME Pricing Pre-Auth Form

THIS SECTION TO BE COMPLETED BY THE PROVIDER OR CLINICAL STAFF

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

A. Provider/Physician Last Name: _____ First Name: _____
Medicaid ID #: _____ Specialist Fax: (____) _____ Specialty Type: _____
B. Reason for Pre-Authorization: [] On FCA Pre-auth List [] Out of Network [] Other: _____
C. Brief History: Include Prior Auth and Surgery: Clinicals Attached: [] N [] Y Number of Pages: _____
D. How soon does patient need to be seen? [] STAT Appointment. [] First Available: [] Routine:
Attending Physician Signature: _____ Physician Medicaid ID #: _____

THIS SECTION IS FOR FCA PRE-AUTHORIZATION DEPT USE ONLY

[] Auth Incomplete: Date Sent Back to Provider: ___/___/___ Incomplete Submittals: [] 1st [] 2nd [] 3rd [] 4th
Incomplete Authorizations must be resubmitted with New Pre-auth Request and requested information/documentation listed below:
Documentation Needed: _____

[] New: [] Updated:

Auth #: _____ Effective Date: ___/___/___ Exp. Date: ___/___/___
Total # of Visits/Units: _____ Other: _____

For Billing Information, Please Call Provider Services: (866) 270-2468
Claims submissions: First Coast Advantage, P. O. Box 3620, Akron, OH 44309-3620