FirstCare Prior Authorization Request Form

(DME, Inpatient Notification, Medical Drug, OON Referral, Prior Authorization)

SECTION I — Submission

Issuer Name: FirstCare Health Plans	MEDICAL/ DME Phone: 800-884-4905 Fax: 800-248-1852	Mental Health/Substance Abuse Phone: 800-327-6943 Fax: 512-233-5949	Date:

SECTION II — GENERAL INFORMATION

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

SECTION III — MEMBER INFORMATION

Member Name:	Phone:	DOB:	Sex: ☐ Male ☐ Female
Subscriber Name (if different):	*Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider			Service Provider or Facility		
Name:	Specialty:		Name:	Specialty	
Ind. NPI:	TPI:		Ind. NPI:	TPI:	
Group NPI:	TIN:		Group NPI:	TIN:	
Contact Name:			Address:		
Phone:	Extension:	Fax:	Contact Name:		
Primary Care Provider Name:			Phone:	Extension:	Fax:

SECTION V — SERVICES REQUESTED AND SUPPORTING DIAGNOSES

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description	DX Code

Number of visits/ units/ days: ________________________________ Modifiers: ___________________________________

☐Referral ☐ Inpatient ☐ Outpatient ☐ Day Surgery ☐ Observation ☐Other:_________________________

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

Number of Visits:_____________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)

☐ Rental ☐ Purchase

SECTION VI — CLINICAL DOCUMENTATION *(Narrative of medical necessity or attach supporting clinical records.)*