Utilization Management
Inpatient Authorization Request for Services

CareFirst
Family of health care plans

INSTRUCTIONS

For Participating Providers: For fastest service, please submit your request via the **CareFirst Provider Portal** (CareFirst Direct) by going to **provider.carefirst.com**. The portal will allow you to check the status of the auth request and receive determinations. If you choose to submit your request via fax, please complete the form and attach clinical documentation to support the medical necessity of the services requested.
Non-Participating Providers: Please complete all fields and attach clinical documentation to support the medical necessity of the service(s) requested. Incomplete information may delay processing your request. Review timelines are based on applicable NCQA, state and federal requirements.

MEMBER INFORMATION

Member Name	Member ID	Member Date of Birth

PROVIDER INFORMATION

Facility Name		NPI
Mailing Address		
City	State	ZIP
Contact Name	Contact Phone Number	Fax Number
Requesting Provider Name		NPI
City	State	ZIP
Contact Name	Contact Phone Number	Fax Number

◯ Check box if requesting and rendering provider is the same. If not, complete below.

Rendering Provider Name		NPI
Mailing Address		
City	State	ZIP
Contact Name	Contact Phone Number	Fax Number

AUTHORIZATION INFORMATION

Admission Date (MM/DD/YYYY) ____ / ____ / _____

Care Setting (Required selection—choose only one)

Physical Health
- ◯ Inpatient Hospital—Medical
- ◯ Inpatient Hospital—Surgical
- ◯ Observation
- ◯ Inpatient Hospice
- ◯ NICU

Post-Acute Inpatient
- ◯ Inpatient Rehab Facility
- ◯ Long-Term Acute Care
- ◯ Skilled Nursing Facility

Behavioral Health
- ◯ Inpatient Psychiatric
- ◯ Residential—Mental Health
- ◯ Residential—Substance Abuse
- ◯ Crisis Unit

Admission Status (Required selection—choose only one)
◯ Not Yet Admitted ◯ Currently Inpatient ◯ Discharged

Treatment Type (Required selection—choose only one)
◯ Medical ◯ Surgical ◯ Substance Use ◯ Behavioral Health

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DIAGNOSIS INFORMATION

	IDC 10 Codes	Description (Include only relevant codes for this request)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

If additional codes are needed, use list section at end of this document.

PROCEDURE INFORMATION

	CPT/HCPCS/REV Code	Description/Level of Care	Expected start date	Expected end date	Number of units/visits/days requested
1					_____ ◯ units ◯ visits ◯ days
2					_____ ◯ units ◯ visits ◯ days
3					_____ ◯ units ◯ visits ◯ days
4					_____ ◯ units ◯ visits ◯ days
5					_____ ◯ units ◯ visits ◯ days
6					_____ ◯ units ◯ visits ◯ days
7					_____ ◯ units ◯ visits ◯ days
8					_____ ◯ units ◯ visits ◯ days
9					_____ ◯ units ◯ visits ◯ days
10					_____ ◯ units ◯ visits ◯ days
11					_____ ◯ units ◯ visits ◯ days
12					_____ ◯ units ◯ visits ◯ days
13					_____ ◯ units ◯ visits ◯ days
14					_____ ◯ units ◯ visits ◯ days
15					_____ ◯ units ◯ visits ◯ days

If additional codes are needed, use list section at end of this document.

URGENT/EXPEDITED

◯ Only select urgent when member's health can be compromised by waiting for standard timeframe

DISCLAIMER

The above approval is based on the number of visits recommended for the diagnosis indicated. If additional visits are required, please complete and submit a separate authorization form indicating measurable short-term and long-term goals for the member.

Prior to rendering the authorized service, the healthcare practitioner must verify the member's eligibility and benefits with CareFirst. If the patient's benefits are not covered on the date the authorized service is delivered, reimbursement will not be provided.

IMPORTANT INFORMATION FOR COMPLETING REQUEST FORMS

Authorization is subject to medical necessity.

1. Requirements for healthcare services vary by employer. Be sure to check the patient's eligibility and benefits. Providers should confirm member eligibility and benefits using CareFirst Direct at **carefirst.com/carefirstdirect** or by contacting CareFirst on Call at 800-842-5975 (CareFirst on Call—Commercial only).
2. General Instructions:
   - Type or print legibly and complete the form in its entirety. Note N/A in blocks that are not applicable.
   - The number of visits and the range for dates of service must agree with those indicated on the claim form. (For example the number of visits cannot be overstated. A visit must not occur outside the approved range for dates of service.) If the claim does not agree with the authorization, claims processing may be delayed and/or the claim may be denied.
3. Fax completed forms to the appropriate Coverage Type fax number listed on the table below. Delays may cause a denial or reduction in claims payment. Please do not send additional pages unless requested (see additional instructions for HMO).

FAX NUMBERS

Coverage type	Fax number
Commercial and Healthy DC	410-720-3063
Community Health Plan Maryland CHPMD	443-552-7407
Medicare Advantage and DualPrime	443-753-2346 (toll-free: 833-915-3865)
Federal Employment Program FEP	410-720-3062

ADDITIONAL DIAGNOSIS INFORMATION

	IDC 10 Codes	Description
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		

ADDITIONAL PROCEDURE INFORMATION

	CPT/HCPCS/REV Code	Description/Level of Care	Expected start date	Expected end date	Number of units/visits/days requested
16					_____ ◯ units ◯ visits ◯ days
17					_____ ◯ units ◯ visits ◯ days
18					_____ ◯ units ◯ visits ◯ days
19					_____ ◯ units ◯ visits ◯ days
20					_____ ◯ units ◯ visits ◯ days
21					_____ ◯ units ◯ visits ◯ days
22					_____ ◯ units ◯ visits ◯ days
23					_____ ◯ units ◯ visits ◯ days
24					_____ ◯ units ◯ visits ◯ days
25					_____ ◯ units ◯ visits ◯ days
26					_____ ◯ units ◯ visits ◯ days
27					_____ ◯ units ◯ visits ◯ days
28					_____ ◯ units ◯ visits ◯ days
29					_____ ◯ units ◯ visits ◯ days
30					_____ ◯ units ◯ visits ◯ days