Medicare Part B Prior Authorization Form

Fax completed form to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Medicare Part B**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Reset Form

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

Drug name: _____ **Start date** (or date of next dose): _____

HCPCS Code: _____ **Date of last dose** (if applicable): _____

Dosage: _____

Dosing frequency: _____

Number of doses requested: _____

Place of administration:
- ☐ Provider's office
- ☐ Outpatient infusion center
- ☐ Home infusion

Center name: _____

Agency name: _____

Billing:
- ☐ Physician buy and bill
- ☐ Preferred specialty vendor
- ☐ Other: _____

ICD code(s)/treatment diagnosis: _____

PriorityMedicare plans

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination (LCD) criteria is available for the state in which the member is receiving the services, the medication must be being used for a medically accepted diagnosis (as defined in the Medicare Benefit Policy Manual Chapter 15 § 50).

Additional information supporting request (attach chart notes and/or labs if applicable):

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 02/2016