Fax to 1-877-266-1871

CARECONTINUUM

Phone 1-800-818-6747

Prior Authorization Request Form

CARECONTINUUM is contracted to provide pre-certification and authorization of home health and/or home infusion services, MDO or AIC services. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Urgency (select one): ☐ YES ☐ NO

Patient Information			
Member Identification Number		Group Number	
Patient Name (Last, First)			Date of Birth (mm/dd/yyyy)
Street Address			
City	State		Zip code
Primary Phone Number		Alternate Phone Number (if available)	

Clinic Information			
Is the billing provider the same as the prescriber? (select one) ☐ YES ☐ NO			
Clinic Name (required)		NPI Number (required)	
Office Contact (if available)		Office Contact Phone Number	
Street Address			
City	State		Zip Code
Phone Number	Fax Number	Email Address	

Prescriber Information			
Prescriber Name (Last, First)		NPI or DEA Number	
Office Contact (if available)		Office Contact Phone Number	
Street Address			
City	State		Zip Code
Phone Number	Fax Number	Email Address	
Prescriber Signature			

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Member ID Number: | Patient Name:

Requested Drug Information			
Request Type (select one): ☐ New Request ☐ Renewal of Previous Approval			
Drug Name		J Code	HCPCS Code
Dose	Frequency		Route
Start Date		End Date	
Diagnosis			
ICD-10 CM Diagnosis Code(s)			
Patient Weight	Patient Height	Patient currently established on therapy (select one) ☐ YES ☐ NO	
Place of Service (select one) Home ☐	Physician's Office ☐	Hospital Outpatient ☐	Ambulatory Fusion Suite ☐
Direction:			
Medical Necessity (clinical and treatment history). Include medications, adverse effects and conditions.			
The following documentation is enclosed for review if the prior approval request (please select): ☐ Office Notes ☐ Medical Records ☐ Other - Describe			