Health Services Preauthorization Form

Submit preauthorization requests to CarePlus Health Plans (CPHP) via **Availity** or **Provider Web Services (PWS)**

Use this form for non-urgent requests by faxing to the corresponding number at the bottom of the form. Attach supporting medical documentation with your request.

Preauthorization guidance is available at the **CarePlus Health Plans website**.

For urgent/same-day services, call the CarePlus Utilization Management provider line at **1-800-201-4305**. Expedited requests must meet the Centers for Medicare & Medicaid Services (CMS) definition: "The healthcare professional or member believes the member's health, life or ability to regain maximum function can be jeopardized if the standard 14 calendar-day timeframe is applied."

REQUEST TYPE(S) ☐ New request ☐ Updated request ☐ Outpatient preauthorization request ☐ Elective inpatient preauthorization request

PART B DRUG REQUEST. If Part B drug, select one box below:
- ☐ The drug is billed, dispensed and administered by physician office, infusion clinic or outpatient facility.
- ☐ The drug is billed and shipped from a retail pharmacy to the physician's office or facility (non-self administered infusible drug). Fax request directly to CPHP Pharmacy at **1-800-310-9071**.

Date of request: _____

Appointment date/time: _____

Valid for: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 year

First Date: _____ Last Date: _____

PATIENT INFORMATION First name: _____ Last name: _____

CarePlus member ID no.: _____ Date of birth: _____ Phone no.: _____

REQUESTING PHYSICIAN/PROVIDER INFORMATION (Check only PCP or Specialist)

☐ PCP ☐ Specialist

Name: _____ Sender's name: _____

Provider ID no.: _____ Tax ID no.: _____ NPI no.: _____

Phone no.: _____ Fax no.: _____

TREATING PROVIDER INFORMATION

Provider name: _____	Facility name: _____
Provider ID no.: _____	Facility ID no.: _____
Tax ID no.: _____	Tax ID no.: _____
NPI no.: _____	NPI no.: _____
Address: _____	Address: _____
Provider phone no.: _____	Provider fax no.: _____

Visits: ☐ Initial ☐ Follow-up Number of visits requested: _____

Provider participates with the CPHP network: ☐ Yes ☐ No

Healthcare facility participates with the CPHP network: ☐ Yes ☐ No

Is request related to an accident? ☐ Yes ☐ No If yes, please specify: ☐ Automobile ☐ Worker's comp ☐ Other _____

ICD-10 diagnosis code/description*	Procedure code/description*	Quantity

* required field(s)

The transmitted information is intended only for the person or entity to which it is addressed. It might contain confidential material. If you receive this document in error, please contact the sender, and delete or destroy the material/information.

336803FL1023 | H1019 HS PrvdPreAuthReqForm 2024

CarePlus Health Plans fax numbers:

Broward and Palm Beach counties: **1-866-832-2678**

Miami-Dade county: **1-888-790-9999**

All others: **1-888-634-3521**