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.

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): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Number of doses requested: _____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Facility: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2019

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):

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