

Request for Referral Authorization or Prior Approval—Medical Procedures

BCBSVT Prior Approvals (referral authorizations are not required for any product) should be faxed to: (802) 371-3491

The Vermont Health Plan Referral Authorizations or Prior Approvals should be faxed directly to one of the following:

Central Vermont PHO Providers: (802) 371-4572 VMC Providers: (802) 847-6213 TVHP: (802) 371-3491

New England Health Plan Referral Authorizations should be faxed to: (802) 371-3491

SECTION 1: Patient Information		
Name (last, first, middle initial):		Other Insurance: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Date of Birth: (mm/dd/yy)	Patient Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Alpha Prefix and Certificate Number:
Primary Diagnosis:		Secondary Diagnosis:

SECTION 2: Referring Provider Information		
Name (last, first, degree) of provider requesting RA/PA:	Phone Number: ()	NPI Number:

SECTION 3: Proposed Rendering Provider		
Name (last, first, degree) of provider/facility who will render service(s):	Phone Number: ()	NPI Number (if located out of state, then full address):

SECTION 4: Please refer to the Quick Reference Grids to determine if Referral Authorization, Prior Approval or no action is required.

<input type="checkbox"/> REFERRAL AUTHORIZATION		
Requested # of visits: <input type="checkbox"/> Evaluate Only	First visit date: (mm/dd/yy)	CPT Code or procedure _____
Type of Referral (check one): <input type="checkbox"/> Ambulance (non-emergent) <input type="checkbox"/> Cardiac Rehabilitation <input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health/Hospice <input type="checkbox"/> Hospital Services <input type="checkbox"/> Out-of-Network (NEHP only)	<input type="checkbox"/> Podiatry Care <input type="checkbox"/> Prosthetic Devices <input type="checkbox"/> Radiology <input type="checkbox"/> Therapy

<input type="checkbox"/> PRIOR APPROVAL	
Requested Service (please refer to prior approval grid for specific procedures, if procedure is not listed, PA is not required): First Visit Date/Proposed Admission/Procedure Date: (mm/dd/yy) CPT Code or Procedure _____	Provide any detailed clinical information pertaining to the procedure/service. Attach supporting documentation if necessary. If the requested service is out-of-network, please specify why these services can't be provided by an in-network provider: See attached notes
Check one of the following categories:	
<input type="checkbox"/> Ambulance <input type="checkbox"/> Capsule Endoscopy <input type="checkbox"/> Chondrocyte Transplant <input type="checkbox"/> Continuous Passive Motion (CPM) <input type="checkbox"/> Dental <input type="checkbox"/> Durable Medical Equipment (this requires a separate form) <input type="checkbox"/> Endocrinology (CPT 95250 & 95251 only)	<input type="checkbox"/> Home Infusion Therapy <input type="checkbox"/> Hospice Care <input type="checkbox"/> Medical Nutrition for inherited metabolic disease <input type="checkbox"/> New Procedure still considered investigational or experimental <input type="checkbox"/> Orthotics <input type="checkbox"/> Osteochondral Autograft Transfer System <input type="checkbox"/> Out-of-Network (VHP & TVHP)
<input type="checkbox"/> Plastic/Cosmetic <input type="checkbox"/> Polysomnography & MSLT <input type="checkbox"/> Private Duty Nursing <input type="checkbox"/> Prosthetics <input type="checkbox"/> Radiology <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Surgery <input type="checkbox"/> TENS Unit <input type="checkbox"/> Transplants <input type="checkbox"/> UPPP/Somnoplasty	

SECTION 5: Signature of Referring Provider & Contact Information	
Referring Providers Signature: _____	Date: _____ (mm/dd/yy)
Referring Providers Name Written Out:	
Name of person to contact if questions regarding this form/recommended services:	Phone Number: ()

In order for a member to obtain coverage for a service, this form must be completed and faxed prior to the service being rendered. Completion of this form does not guarantee benefits.

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