

HCPCS (Healthcare Common Procedure Coding System) Authorization Form



Fax to AmeriHealth Caritas Next at **1-833-971-8824**. For urgent faxes: **1-833-977-8871**.

To speak to a representative call **1-844-317-0779**.

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Confidential information			
Patient name:			
Patient date of birth (MM/DD/YYYY): ____/____/____		Patient ID number:	
Physician name:	Physician Tax ID:	Specialty:	
Phone:	Fax:	Physician NPI:	
Physician street address:			
City:		State:	ZIP code:
Facility name:		Facility NPI:	
Facility street address:		Facility Tax ID:	
Facility city:		State:	ZIP code:
Treatment setting: <input type="checkbox"/> Infusion Center <input type="checkbox"/> Home <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital Outpatient Facility			
Medication name and strength requested:		J-code: _____	
		Number of units: _____	
		Date of service (MM/DD/YYYY): ____/____/____	
Directions:			
Medication name and strength requested:		J-code: _____	
		Number of units: _____	
		Date of service (MM/DD/YYYY): ____/____/____	
Directions:			
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		Number of units: _____	
		Date of service (MM/DD/YYYY): ____/____/____	
Directions:			
Medication name and strength requested:		J-code: _____	
		Number of units: _____	
		Date of service (MM/DD/YYYY): ____/____/____	
Directions:			
Anticipated length of therapy: <input type="checkbox"/> days <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months			
Diagnosis:			

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Preferred medications tried/Previous therapy. Please include strength, frequency, and duration. (If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs.)

Rationale and/or additional information that may be relevant to the review of this prior authorization request. (If more space is needed, please attach an additional page to this document.)

Physician signature:

Date (MM/DD/YYYY): ____/____/____