Humana
Behavioral Health

Florida Prior Authorization Form for Medical Procedures, Courses of Treatment or Prescription Drug Benefits (OIR-B2-2180)

Please fax to 1-800-807-1898. If you have questions about our prior authorization requirements, please call 1-800-777-6330.

Incomplete forms will be returned for additional information. Please follow Health Insurance Portability and Accountability Act (HIPAA) guidelines when submitting this form.

1. PRIORITY (MARK ONLY ONE):

[ ]	a. Standard	
[ ]	b. Date of service	Services are scheduled to begin this date:
[ ]	c. Urgent	Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the patient.

2. PATIENT INFORMATION: Complete all fields

a. First name:	b. Last name:	c. MI:	d. DOB (mm/dd/yyyy):
e. Gender: [ ] Male [ ] Female	f. Height:	g. Weight:	
h. Street address:	i. City, state, ZIP:	j. Phone:	
k. Health plan ID#:		l. Group #:	

3. ORDERING PHYSICIAN/CLINIC/FACILITY INFORMATION:

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact name:
e. Clinic name:		f. Clinic street address:	
g. City, state, ZIP:		h. Phone:	i. Fax or email:

4. RENDERING PHYSICIAN/CLINIC/FACILITY/PHARMACY INFORMATION: [ ] Check if same as No. 3

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact name:
e. Physician/clinic/facility/pharmacy name:		f. Street address:	
g. City, state, ZIP:		h. Phone:	i. Fax or email:

5. REQUESTED MEDICAL PROCEDURE/COURSE OF TREATMENT/DEVICE INFORMATION:

a. Service type (choose one): [ ] CD [ ] MH
b. Choose one level of care from Outpatient/Office or Inpatient or provide an answer in Other and fill out No. 7 on the next page: - Setting/CMS POS code: Outpatient/Office [ ] IOP [ ] PHP [ ] OP [ ] TMS [ ] ECT [ ] Psych Testing - Setting/CMS POS code: Inpatient (IP) [ ] IP [ ] IP-Rehab [ ] RTC (Sub-acute) - Other *(please provide description and fill out No. 7):*
c. Revenue code:
d. Estimated length of stay for level of care:
e. Provide any tentative discharge plan information:

6. HCPCS/CPT/CDT CODES:

a. Latest ICD code	b. HCPCS/CPT/CDT code	c. Code description	d. Medical reason *(if applicable)*

Other clinical information – Include/attach clinical/office notes, laboratory information, imaging reports and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.

7. OTHER SERVICES *(*noted from No. 5 – if applicable)*:

a. Type of service:	b. Name of therapy/agency:	
c. Units/volume/visits requested:	d. Frequency/length of time needed:	e. Initial [ ] Extension [ ] Previous authorization number:
f. Additional comments:		

8. PRESCRIPTION DRUGS *(This space is for new medication requests only. List current prescriptions in the attached clinical information.)*

a. Diagnosis name and code:			
b. Medication requested	c. Strength	d. Dosing schedule (including length of therapy)	e. Quantity per month or quantity limits
f. Is the patient currently treated with requested medication(s)? [ ] Yes [ ] No If yes, when was treatment with the requested medication started? _____			
g. Explain the medical reasons for the requested medications. Include an explanation for selecting the medications over alternatives.			
h. List any other medications the patient will use in combination with requested medication:			

9. PREVIOUS SERVICES/THERAPY (INCLUDING DRUG, DOSE, DURATION AND REASON FOR DISCONTINUING PREVIOUS THERAPY) *(if applicable)*:

a.	Date discontinued
b.	Date discontinued
c.	Date discontinued

10. ATTESTATION

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Provider signature:_____ Date:_____

Written notification will be provided for request determination results, regardless of plan decision.

Instructions for OIR-B2-2180, Florida Prior Authorization Form for Medical Procedures, Courses of Treatment or Prescription Drug Benefits

1. **PRIORITY.** Only one of the following options should be marked.
    a. Standard should be marked if the prior authorization request is not an urgent request or the medical service has not been scheduled.
    b. Date of Service should be chosen if the requested medical service has been scheduled for a future date. The scheduled date should be written in the corresponding box to the right of the Date of Service label. Note that this is for informational purposes only and that the health insurance issuer is not obligated to provide authorization.
    c. Urgent should be marked if the patient's life may be seriously jeopardized by applying the standard review time.
2. **PATIENT INFORMATION.** All boxes should be completed.
3. **ORDERING PHYSICIAN/CLINIC/FACILITY INFORMATION.** Fill in all applicable boxes for the physician who is requesting the medical service.
    b. Enter the provider's unique tax identification number (TIN) or national provider identification (NPI) number.
4. **RENDERING PHYSICIAN/CLINIC/FACILITY/PHARMACY INFORMATION.** If the ordering physician is the same as the rendering physician, check the box next to the title. You do not need to complete the rest of this section unless any information differs from that provided in section 3. If the requesting physician is not the rendering physician, fill in all of the applicable boxes for the physician who will perform or administer the medical service.
    b. Fill in the provider's unique tax identification number or national provider identification number.
5. **REQUESTED MEDICAL PROCEDURE/COURSE OF TREATMENT/DEVICE INFORMATION.**
    a. Choose if the service requested is for Chemical Dependency (CD) or Mental Health (MH) services.
    b. Mark the box indicating where the requested service will be performed or given. If 'Other' is selected, state where the requested medical service or device will be given. IOP – Intensive outpatient; PHP – Partial hospitalization program; OP – Outpatient; TMS – Transcranial magnetic stimulation; ECT – Electroconvulsive therapy.
    c. Enter your revenue code.
    d. Enter the estimated length of stay for the indicated level of care.
    e. Enter any tentative discharge plan information.
6. **HCPCS/CPT/CDT CODES.** State the Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) and/or Current Dental Terminology (CDT) code(s) that apply to the requested medical services or procedures.
    a. Enter the most current International Classification of Diseases (IDC) code used to classify and code the diagnosis, symptom or procedure applicable to the patient's condition.
    b. Enter the applicable HCPCS, CPT and/or CDT codes.
    c. Fill in each code description.
    d. Provide a medical reason for requesting the medical service.

Other Clinical Information– Include/attach clinical/office notes, laboratory information, imaging reports and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.

7. **OTHER SERVICES.** Complete this section only if the requested medical service does not fall within the other sections. Examples of other services may include, but are not limited to, rehabilitation services and home health care services.

8. **PRESCRIPTION DRUGS**. Complete this section if you are requesting new prescription drugs. Current patient medications should be included in the attached clinical information.
    a. Enter the diagnosis name and code of the condition the prescription drug will be used to treat.
    b. Detail the medication requested.
    c. Detail the strength of the medication requested.
    d. Detail the dosing schedule of any medication requested, including the length of therapy.
    e. Detail the quantity per month or quantity limit of the medication requested.
    f. Check the appropriate box and, if YES, enter the date treatment started with the requested medicine.
    g. Explain the medical reasons for the requested medication(s). Include an explanation for selecting the medication(s) over alternatives.
    h. List any other medications the patient will use in combination with the requested medication.

9. **PREVIOUS SERVICES/THERAPY.** Complete this section only if the patient has had previous therapy relating to the requested service.

10. **ATTESTATION.** The requesting health care professional must truthfully certify that all information provided as part of the prior authorization request is true and accurate.