BOSTON MEDICAL CENTER
HEALTHNet PLAN

MEDICAL PRIOR AUTHORIZATION REQUEST FORM

NOTE: PLEASE ATTACH SUPPORTING CLINICAL INFORMATION WITH ALL REQUESTS
INCOMPLETE INFORMATION MAY DELAY PROCESSING OF REQUEST

FAX TO: 617-951-3464 (initial requests); 617-951-3461(additional clinical information); 617-951-3463 (emerg. and inpt)

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Member Information

Member Name: _____ DOB: _____ BMCHP ID #: _____

Submitted by / Sender Information

Submitted by: _____ Phone # (direct line): _____ Fax #: _____
Who sent in the form?

Provider Information

Requesting Provider Name: _____ NPI #: _____ □ PCP □ Specialist

Servicing Provider Name: _____ NPI #: _____

Servicing Provider Address: _____ Phone #: _____ Fax #: _____
Where will member be seen?

Servicing Facility Name:_____ NPI #: _____

Requested Services

Office Visit / Consult: □ Primary Care □ OB: EDC (required) _____ □ Specialist: Type: _____

Visit Date: _____ # Visits: _____ Last Visit Date: _____ Diagnosis Code(s): _____ CPT Code(s): _____

Surgery: □ Inpatient □ Outpatient □ Post-op Observation: _____hours Scheduled date: _____

Diagnosis Code(s): _____ CPT Code(s): _____

Outpatient Rehab: □ PT: # visits _____ Date range: _____ □ OT: # visits _____ Date range: _____

□ ST: # visits _____ Date range: _____

Diagnosis Code(s): _____ CPT Code(s): _____

Home Health Care: □ RN: # visits _____ Date range: _____ □ PT: # visits _____ Date range: _____

□ OT: # visits _____ Date range: _____ □ ST: # visits _____ Date range: _____

□ SW: # visits _____ Date range: _____ □ HHA: # visits _____ Date range: _____

□ Other: _____ # visits _____ Date range: _____
Specify type

Diagnosis Code(s): _____ CPT Code(s): _____

DMEPOS**: HCPCS Code Modifier Description Quantity (Units/Calories) Cost

_____

_____

For DMEPOS provider requests and requests for oral enterals by any provider, contact Northwood at 866-802-6471 for authorization.

Additional Comments:_____

_____

The number you will receive from the BMC HealthNet Plan Prior Authorization Department is a reference number; it is not a guarantee of payment. Payment is based upon eligibility of the member on the date of service, verification of the service as a covered benefit, and medical necessity. Submission of cost or charge information does not guarantee payment at those rates. The Plan reimburses providers based on MassHealth rates unless otherwise contractually specified.

Member line ph# 888-566-0010 (MassHealth) or 877-957-5300 (Commonwealth Care); Provider line ph# 888-566-0008