

**CLINICAL REVIEW PREAUTHORIZATION
REQUEST FORM – MEDICARE ADVANTAGE**



Please use this form for general preauthorization requests and site-of-service reviews. **Fax completed form with supporting medical documentation to Clinical Review at 1-866-706-6929.**

Services are not considered authorized until ConnectiCare issues an authorization. Failure to submit complete information will delay processing of request.

See separate forms to submit preauthorization requests for Home Health Care, IV Therapy or Out-of-Network Services.

***Required information**

Member information	
*Date:	*Member ID number:
*Member name:	*Member date of birth:
Requesting provider	
*Requesting provider:	*Office contact name:
*Requesting provider ID number:	*Office contact phone number (including ext.):
*Tax ID number:	*Office contact fax number:
*Is physician employed by a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name the hospital:	
Requested service details	
*Dates of service:	*ICD-10:
*CPT codes:	*HCPCS codes:
*Servicing provider:	*Site of service: <input type="checkbox"/> Ambulatory surgical center (ASC) <input type="checkbox"/> Outpatient hospital If outpatient hospital is selected, please provide the hospital's name:
*Does servicing provider have privileges at an ambulatory surgical center (ASC)? <input type="checkbox"/> Yes <input type="checkbox"/> No Provide reason why the site of service is being requested for procedure (attach additional pages if needed):	

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Services/procedures requested	
<input type="checkbox"/> Ambulance/medical transport (non-emergent) <input type="checkbox"/> Cardiac monitoring (ambulatory ECG) <i>Preauthorization is NOT required for standard Holter monitors and loop event recorders.</i> <input type="checkbox"/> Clinical trial (patient consent form is required) <input type="checkbox"/> DME, including but not limited to: ___ Bone growth stimulator ___ Power-operated wheelchair or scooter ___ Oral appliance for the treatment of sleep apnea ___ Other _____	<input type="checkbox"/> Mammoplasty** (photos required) <input type="checkbox"/> Pulmonary Rehabilitation <input type="checkbox"/> Reconstructive surgery <input type="checkbox"/> Transplant services, except corneal <input type="checkbox"/> Ventricular Assist Device <input type="checkbox"/> Other _____
Services/procedures for site-of-service reviews	
<input type="checkbox"/> Dermatology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Gynecology	<input type="checkbox"/> Ophthalmology <input type="checkbox"/> Urology

**To properly facilitate your request for mammoplasty, please mail this form, medical documentation and photos to:

ConnectiCare
 Attn: Clinical Review Department,
 175 Scott Swamp Road
 Farmington, CT 06032-3124

Call the Clinical Review Department at 1-800-508-6157 (select option #1) with any questions about preauthorization. General provider questions, please call Provider Services at 1-877-224-8230.