

Member Name:	Member ID #:
	Member DOB:
Requesting Provider:	Office Contact Name:
Requesting Provider ID #:	Office Contact Phone # and Ext:
Tax ID #:	Office Contact Fax #:
ICD-9/CPT/HCPCS Code(s):	Servicing Provider:
Requested Service/Procedure Dates of Service:	

Fax Completed Form with Supporting Medical Documentation to Clinical Review at 1-800-923-2882 or 1-860-674-5893

Services/Procedures Requested

- | | |
|--|---|
| <input type="checkbox"/> Ambulance/medical transport (non-emergent) | <input type="checkbox"/> Formula, enteral nutrition or food products |
| <input type="checkbox"/> Artificial intervertebral disc | <input type="checkbox"/> Genetic testing (e.g. BRCA, colon cancer screening, FISH testing, Oncotype DX) |
| <input type="checkbox"/> Bariatric surgery (if a covered benefit) | <i>Pre-Authorization is NOT required for routine chromosomal analysis, cystic fibrosis DNA testing, and fluorescent in situ hybridization for the diagnosis of lymphoma or leukemia when the appropriate modifier is used.</i> |
| <input type="checkbox"/> Cancer clinical trial | <input type="checkbox"/> Mammoplasty* including surgery to treat gynecomastia (photos required) |
| <input type="checkbox"/> Cardiac monitoring (ambulatory ECG)
<i>Pre-Authorization is NOT required for standard holter monitors and loop event recorders.</i> | <input type="checkbox"/> Obstructive sleep apnea surgery
(e.g., UPPP, hyoid myotomy & suspension, mandibular osteotomy, mandibular-maxillary osteotomy, advancement, and tracheostomy) |
| <input type="checkbox"/> Chondrocyte implantation or transplantation, osteochondral allograft | <input type="checkbox"/> Reconstructive surgery |
| <input type="checkbox"/> Corneal pachymetry (repeat testing only) | <input type="checkbox"/> Septoplasty* (photos required)
<i>No pre-authorization needed when performed by an ear, nose and throat specialist</i> |
| <input type="checkbox"/> Craniofacial treatment | <input type="checkbox"/> TMJ surgery |
| <input type="checkbox"/> Dental anesthesia and facility charges | <input type="checkbox"/> Transplant services, except corneal |
| <input type="checkbox"/> DME, including but not limited to: | <input type="checkbox"/> Vagus Nerve Stimulation for the treatment of epilepsy |
| ___ Bone growth stimulator | <input type="checkbox"/> Varicose vein surgery* (high-quality color photos are required with body location labeled and ruler next to varicosities) |
| ___ Customized wheelchair, power mobility device, scooter | <input type="checkbox"/> Other _____ |
| ___ Continuous glucose monitor | |
| ___ Insulin pump | |
| ___ Upper/lower limb prosthetic | |
| ___ Mechanical stretching device | |
| ___ Oral appliance for the treatment of sleep apnea | |
| ___ Wound vac | |
| ___ Other _____ | |

Fax form and medical documentation to Clinical Review at 1-800-923-2882 or 1-860-674-5893

***To properly facilitate your request for Mammoplasty, Septoplasty or Varicose Veins, please mail this form, medical documentation and photos to:
ConnectiCare, Attn: Clinical Review Department, 175 Scott Swamp Road, Farmington, CT 06032-3124**

Please Note:
Services are not considered authorized until ConnectiCare issues an authorization.
Lack of information will delay processing of request.

See separate forms to submit pre-authorization requests for Home Health Care, Infertility, IV Therapy, or Out of Network Services.
Please contact Clinical Review at 1-800-562-6833 (select option #4) with any questions about pre-authorization.
This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407.