CLINICAL REVIEW PREAUTHORIZATION REQUEST FORM - COMMERCIAL

ConnectiCare

Please use this form for general preauthorization requests and site-of-service reviews. **Fax completed form with supporting medical documentation to Clinical Review at 1-800-923-2882 or 1-860-674-5893.**

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, Infertility, 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? ☐ Yes ☐ No If yes, please name the hospital:	
Requested service details	
*Dates of service:	*ICD-10:
*CPT codes:	*HCPCs codes:
*Servicing provider:	*Site of service: ☐ Ambulatory surgical center (ASC) ☐ Outpatient hospital If outpatient hospital is selected, please provide the hospital's name:
***Does servicing provider have privileges at an ambulatory surgical center (ASC)?** ☐ Yes ☐ 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

- ☐ Ambulance/medical transport (non-emergent)
- ☐ Artificial intervertebral disc (if a covered benefit)
- ☐ Bariatric surgery (if a covered benefit)
- ☐ Clinical trial (patient consent form is required)
- ☐ Cardiac monitoring (ambulatory ECG)

  *Preauthorization is **NOT** required for standard holter monitors and loop event recorders.*
- ☐ Craniofacial treatment
- ☐ DME, including but not limited to:
  - ___ Bone growth stimulator (if a covered benefit)
  - ___ Customized wheelchair, power mobility device, scooter (if a covered benefit)
  - ___ Oral appliance for the treatment of sleep apnea
  - ___ Other _____
- ☐ Formula, enteral nutrition or food products
- ☐ Gender reassignment surgery
- ☐ Mammoplasty** including surgery to treat gynecomastia (photos required) (if a covered benefit)
- ☐ Mandibular-Maxillary osteotomy for the treatment of obstructive sleep apnea
- ☐ Reconstructive surgery
- ☐ Transplant services, except corneal
- ☐ Varicose vein surgery** (if a covered benefit)
- ☐ Ventricular Assist Device
- ☐ Other _____

Services/procedures for site-of-service reviews

- ☐ Dermatology
- ☐ Gastroenterology
- ☐ Gynecology
- ☐ Ophthalmology
- ☐ Urology

**To properly facilitate your request for mammoplasty and varicose veins, 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 1-800-562-6833 (select option #4) with any questions about preauthorization. General provider questions, please call Provider Services at 1-800-828-3407.