

Date:	Member ID #:
Member Name:	Member DOB:
Requesting Provider:	Provider Office Contact Name:
Requesting Provider ID #:	Office Contact Phone # and Ext:
Tax ID #:	Office Contact Fax #:
Dates of Service:	Servicing Provider:
ICD-9*/ICD-10*/CPT/HCPCS Code(s):	

* Services or inpatient discharges prior to Oct. 1, 2015 must use ICD-9 codes; services or inpatient discharges after Oct. 1, 2015 must use ICD-10 codes.

Fax Completed Form with Supporting Medical Documentation to Clinical Review at 1-866-706-6929

Services/Procedures Requested

- | | |
|---|---|
| <input type="checkbox"/> Ambulance/medical transport (non-emergent)
<input type="checkbox"/> Cardiac monitoring (ambulatory ECG)
<i>Pre-Authorization is <u>NOT</u> required for standard holter monitors and loop event recorders.</i>
<input type="checkbox"/> Clinical trial (copy of the patient consent 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"/> Genetic testing
<i>Pre-Authorization is required except for the following tests:</i> <ul style="list-style-type: none"> • Chromosomal microarray analysis • Cystic Fibrosis – screening only • Factor V Leiden • FISH testing for diagnosis of lymphoma or leukemia • Fragile X • Hereditary hemochromatosis • Prothrombin <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 _____ |
|---|---|

Fax form and medical documentation to Clinical Review at 1-866-706-6929

****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**

**Please Note:
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 pre-authorization requests for Home Health Care, IV Therapy or Out-of-Network Services.

Please contact Clinical Review at 1-800-508-6157 (select option #1) with any questions about pre-authorization.
This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-877-224-8230.



ConnectiCare, Inc. is an HMO/HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal.

ConnectiCare Insurance Company, Inc. is an HMO SNP plan with a Medicare contract and a contract with the Connecticut Medicaid Program. Enrollment in ConnectiCare depends on contract renewal.

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