

HealthSCOPE Benefits, Inc.

Medical Management Guidelines

INPATIENT PRIOR AUTHORIZATION REQUIREMENTS:

Hospital Admission	Pre-admission authorization is required for elective and impending hospitalization prior to the admission (at least 7 days). Elective admissions will be denied for payment unless prior authorized. ADMISSIONS: REQUIRE TIMELY NOTICE FROM THE HOSPITAL. CLINICAL INFORMATION MUST BE CALLED IN AND MAY BE LEFT ON CONFIDENTIAL VOICE MAIL.
Non-Elective Admissions on Weekends or Holidays	Notification should be left on voice mail. <i>No elective admissions should occur on Weekends without prior authorization.</i>
OB Admission	Notification is required.
Admission to NICU	Notification must be made within 24 hours of a transfer.

MANDATORY PRIOR AUTHORIZATION LIST

- Inpatient Hospitalization/Services, including Mental Health
- Inpatient Emergency Services (within 24 hours)
- Transplantation Evaluations and Procedures
- Gastric Bypass Procedures
- Sclerotherapy
- Endovascular Procedures
- PET Scan
- Therapies (speech, occupational, physical)
- Home Health Care
- Hospice
- Chemotherapy
- DME – Any DME \$1000.00 and over which can include the following but not limited to: Wound Vacuums, Bone Growth Stimulators, CPAP machine and supplies, Oxygen, Wheelchairs and Hospital beds.

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- ◆ Authorizations cannot be issued without the appropriate information to determine medical necessity. An authorization number will be assigned to the case once complete information is received.
 - ◆ Prior authorization requests are returned to the requesting provider via fax within 24 to 48 business hours of receipt of properly completed form.
 - ◆ No prior authorization needed for outpatient emergency services.
(Emergency: an illness or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. This includes accidental injuries or medical emergencies of a life-threatening nature or when serious impairment of bodily functions would result if treatment were not rendered immediately).
 - ◆ Please note Prior Authorization is required for secondary coverage under HealthSCOPE Benefits, Inc., unless Medicare is their primary coverage.
 - ◆ No prior authorization required for members with Medicare as primary coverage.

Effective 1/20/2011

**HealthSCOPE Benefits, Inc.
PRIOR AUTHORIZATION FORM**

**PLEASE FILL OUT THE FORM COMPLETELY AND SUBMIT
DOCUMENTATION REGARDING THE DIAGNOSIS FOR WHICH SERVICES
ARE BEING REQUESTED TO FAX NUMBER: (915) 760-8613**

PRECERT/AUTHORIZATION #: _____

DATE OF REQUEST: _____ CONTACTPERSON: _____

PHONE NUMBER: _____ FAXNUMBER: _____

NAME OF CARDHOLDER: _____ I.D.# _____

PATIENT NAME: _____ GROUP#: _____ D.O.B.: _____

PHYSICIAN REQUESTING SERVICES: _____

SERVICE REQUESTED: _____ CPT CODE: _____

DIAGNOSIS: _____ ICD-9CODE: _____

FACILITY/HOSPITAL: _____ TELEPHONE#: _____

TIN: _____ FAX NUMBER: _____

OUTPATIENT INPATIENT D.O.S.: _____

THERAPIES: PT, OT, ST, HOME HEALTH CARE & WOUND CARE **PLEASE PROVIDE
FREQUENCY & DURATION, (BEGINNING & ENDING DATES):** _____

SUPPORTING DOCUMENTATION SHOULD INCLUDE THE FOLLOWING:

PROVIDER PROGRESS NOTES YES NO OTHER: _____

SPECIALIST NOTES/CONSULT REPORTS YES NO OTHER: _____

**TURN AROUND TIME WILL BE FROM 24 TO 48 HOURS FROM THE TIME OF RECEIPT OF
PROPERLY COMPLETED FORM WITH PERTINENT CLINICAL INFORMATION AS
APPROPRIATE. IF YOU DO NOT RECEIVE A RESPONSE AFTER 48 HOURS CONTACT THE
MEDICAL MANAGEMENT DEPARTMENT AT 915-231-4277. WORKING HOURS ARE: 8:00
A.M. TO 5:30 P.M., MONDAY THROUGH FRIDAY. TELEPHONES WILL BE ANSWERED BY
VOICE MAIL ON WEEKENDS, HOLIDAYS AND AFTER HOURS.**

**NO PRIOR AUTHORIZATION REQUIRED FOR MEMBERS WITH
MEDICARE AS PRIMARY COVERAGE***

**“This authorization for services is not a guarantee of payment. Any benefits are
subject to the payment of premium or employer contribution for the date on which
services are rendered. An authorization for services or a description of benefits is
not an acknowledgement that premium or employer contribution has been paid. All
claims are subject to medical necessity, other contract limitations and provisions
and services must be provided or authorized by the Attending Physician.”**

REVISED 02/09/06
REVISED 07/01/06
REVISED 03/28/07
REVISED 03/05/09