FirstMedicare Direct

FIRSTCAROLINACARE INSURANCE COMPANY

PRIOR AUTHORIZATION REQUEST

Please fax to 816-313-3060

SECTION 1

TODAY'S DATE: ADMIT/PROCEDURE DATE: # VISITS/DAYS REQUESTED ______________________

PERSON COMPLETING FORM:________________________ PHONE #_____________ FAX # ______________________

SECTION 2 – MEMBER/PATIENT INFORMATION

NAME:____ DOB:______________________

MEMBER ID# _________________________

SECTION 3 – ORDERING PROVIDER

NAME:____ TAX ID #: _________________________

PHONE #_________________________________ NPI #: ___________________________

SECTION 4 – PLACE OF SERVICE

NAME:____ TAX ID #: _________________________

DIAGNOSIS:____ICD 10- CODES:_____________NPI #: _________________

PROCEDURE____ CPT/HCPCS CODES:_____INPT________OUTPT_______

SECTION 5 – SERVICES REQUESTED

Inpatient Services

____ Inpatient Hospitalization

____ LTAC

____ Rehab (IRC)

____ SNF

____ Behavioral Health

Transplant (Organ, Bone Marrow, Stem)

Outpatient Services

____Genetic Testing

____Drugs on the PA List

____Other _______________

____DME ____Prosthetics ____Orthotics (Precert required for purchased items $1,000.00 or more and ALL DME rentals

DME Item Name ____________________________________

HCPCS Codes______________________________________

Prosthetics_______________________________________

Orthotics ____

Out of Network Request

____HMO/HMO Plus Member

____ PPO Members for services requiring PA

IMPORTANT: Must fax all pertinent clinical information (i.e. Office visit notes, imaging, labs) along with this request

SECTION 6 – ADDITIONAL INFORMATION- Please add additional CPT/HCPCS codes or special instructions below.

For questions or additional information, please call 844-201-4957 (Option 3, then 2)

For FCCI Use Only Authorization #___________________ FirstMedicare Direct Contact____________________

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