

HCPCS (Healthcare Common Procedure Coding System) Authorization Form



Confidential information

Patient name:		
Patient date of birth (MM/DD/YYYY): / /		Patient ID number:
Physician name:		Specialty:
Phone: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Fax: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	NPI: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Physician street address:		
City:		State: ZIP code:
Facility name:		Facility NPI:
Medication name and strength requested:		J-code: Number of units: Date of service (MM/DD/YYYY): / /
Directions:		
Anticipated length of therapy: <input type="checkbox"/> Days <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months		
Treatment setting: <input type="checkbox"/> Outpatient <input type="checkbox"/> Home infusion <input type="checkbox"/> In-office <input type="checkbox"/> Other:		
Diagnosis:		
Preferred medications tried/Previous therapy. Please include strength, frequency, and duration. (If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs.)		
Rationale and/or additional information that may be relevant to the review of this prior authorization request. (If more space is needed, please attach an additional page to this document.)		
Physician signature:		Date (MM/DD/YYYY): / /

Please return this form to:

PerformRx
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

Fax to:

AmeriHealth Caritas Pennsylvania
Community HealthChoices:
1-855-851-4058

Important payment notice

Please note that reimbursement for all rendering network providers subject to the ordering/referring/prescribing (ORP) requirement for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medical Assistance (MA) Provider ID. Effective January 1, 2018, any claim submitted by rendering network providers that are subject to the ORP requirement will be denied when billed with the NPI of an ORP provider that is not enrolled in MA.

To check the MA enrollment status of the practitioner ordering, referring, or prescribing the service you are providing, visit the Department of Human Services (DHS) provider look-up portal at: <https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider>.