HCPCS (Healthcare Common Procedure Coding System) Authorization Form

AmeriHealth Caritas District of Columbia

HEALTHY DC PLAN

CONFIDENTIAL INFORMATION

Patient name:			
Patient date of birth (MM/DD/YYYY):		Patient ID number:	
Physician name:	Physician Tax ID:	Specialty:	
Phone:	Fax:	NPI:	
Physician street address:			
City:		State:	ZIP Code:
Facility name:		Facility NPI:	
Facility street address:		Facility Tax ID:	
Facility city:		State:	ZIP Code:
Treatment setting: ☐ Infusion center ☐ Home ☐ Provider's office ☐ Hospital outpatient facility			
Medication name and strength requested:		J-code: Number of units: Date of service (MM/DD/YYYY): / /	
Directions:			
Anticipated length of therapy: ☐ Days ☐ 3 months ☐ 6 months			
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. Fax to: 1-844-480-2486 or call 1-855-332-0992.

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