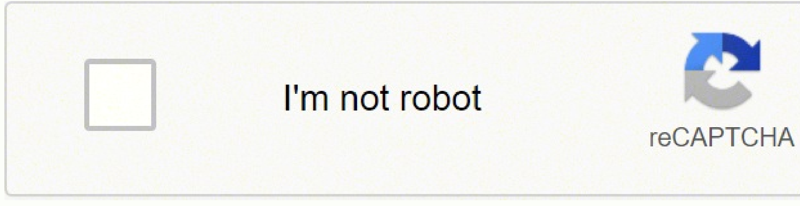

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Anthem bcbs prior authorization form for dme

Global Non-formulary Prior Authorization Form

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Anthem Blue Cross and Blue Shield Medicaid at **1-855-875-3627**. Please contact Anthem Blue Cross and Blue Shield Medicaid at **1-855-661-2028** with questions regarding the prior authorization process.

Drug Name
Please specify:

Patient Information	
Patient Name:	
Patient ID:	
Patient Group No.:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
NPI:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State ZIP Code:	

Diagnosis:		**ICD Code:**	
Please circle the appropriate answer for each question.			
1. Is this an office-administered injectable drug?	☐ **YES**	☐ **NO**	
2. Is the intent to provide and bill for this medication at the physician's office? (If the answer to this is yes, then please call Provider Services at **1-855-661-2028** or fax Provider Services at **1-855-875-3627** for review.)	☐ **YES**	☐ **NO**	
3. Is the requested drug being used for an FDA-approved indication?	☐ **YES**	☐ **NO**	
4. Is the requested drug being used for an indication that is supported by information from the appropriate compendia of current literature (e.g., AHFS, Micromedex, current accepted guidelines, etc.)?	☐ **YES**	☐ **NO**	
5. Has the patient demonstrated a failure of or intolerance to a majority (not more than three) of the preferred formulary/PDL alternatives for the given diagnosis?	☐ **YES**	☐ **NO**	

Anthem Blue Cross and Blue Shield
P.O. Box 27401 • Richmond, VA 23279-7401

Application for Medicare Supplement and Anthem Extras – Virginia

☐ New Enrollment
☐ Change to Existing Anthem Medicare Supplement Plan

Send no money now!
For assistance, please contact your Farm Bureau Agent or call us at 1-800-916-2583. To be considered for coverage, you must live in the Anthem Blue Cross and Blue Shield service area in Virginia. Please answer all questions fully.

Section A: Applicant Information (Please print and use black ink only.)

Last Name	First Name		MI	Sex ☐ M ☐ F
Home Street Address (Physical Address, not a P.O. Box)				Apt #
City	County		State	ZIP Code
Mailing Address (if different than above)	City		State	ZIP Code
Billing Address (if different than above)	City		State	ZIP Code
Social Security Number	Date of Birth	Age		Home Phone Number ( )
Email Address (optional)	Preferred Language Spoken:	Written:		

Section B: Medicare Information (From your red, white and blue Medicare card.)
NOTE: The below information is required to complete your enrollment. Enrollment in Original Medicare is required.

Medicare Claim Number: ______________

Hospital (Part A) Effective Date: ______ MONTH/YEAR

Medical (Part B) Effective Date: ______ MONTH/YEAR

MEDICARE HEALTH INSURANCE
NAME OF BENEFICIARY
MEDICARE CLAIM NUMBER
SEX
FEMALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL (PART A)
MEDICAL (PART B)

Is a member of your household enrolled in or applying for a Medicare Supplement plan with us? ☐ Yes ☐ No

If "Yes," you may be eligible for a discount on your premium.* Please provide the following information for that household member:

Name ______________ Medicare Claim Number ______________

Anthem Blue Cross and Blue Shield Medicare Supplement Identification Number ______________

*See the Outline of Coverage – Premium Information page for details.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER APPEAL FORM
PO Box 33200
Louisville, Kentucky 40232-3200

With the exception of appeals of adverse Precertification decisions, all requests for review must first be submitted to the appropriate Provider Inquiry Unit as a complaint. If you are not satisfied with our response to your complaint, you may request an appeal. A Participating Provider's request for Anthem Blue Cross and Blue Shield (Anthem) to change a reimbursement amount for a service, including disputes regarding bundling, and coding, shall be handled exclusively as a Complaint. To avoid unnecessary delays in the handling of your appeal, please include a copy of our written response to your complaint regarding the issue being appealed.

DATE: ______/________/________ MEMBER ID NUMBER: ____________________

MEMBER NAME ______________________ PATIENT NAME __________________

DATE OF SERVICE __________________ DATE PAID ________________________

ANTHEM CLAIM NUMBER ____

REASON FOR APPEAL (Please be specific and attach additional pages, if necessary).

THE FOLLOWING DOCUMENTATION IS ENCLOSED FOR REVIEW OF THIS APPEAL:

CLAIM FORM ____ OFFICE NOTES _____ PAYMENT VOUCHER ____ MEDICAL RECORDS ____

X-RAYS ____ OTHER ______________________________

PHYSICIAN/FACILITY NAME ____

PHYSICIAN/FACILITY ADDRESS ____

CITY ____________________ STATE ____ ZIP _______ COUNTY _________________

PROVIDER TELEPHONE NO (____) ________ PROVIDER ID NO. ____________________

DATE OF COMPLAINT RESPONSE ____________________

PHYSICIAN/HOSPITAL SIGNATURE _____________________________________

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EMPLOYEE HEALTH ENROLLMENT APPLICATION

(Group Size 15+)

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. The Primary Care Physician (PCP) listings of Anthem and its affiliated HMO companies can be obtained through www.anthem.com.

APP

EMPLOYER/GROUP USE ONLY

Group Name		Group Number		Effective Date M D Y
Date of hire	Full time hire date	# Hours working per week	Date of eligibility for coverage	

1. CHECK COMPANY(S) AND WRITE IN PRODUCT THAT APPLIES. APPLICATION COMPLETED FOR:

- ❑ **Anthem Blue Cross and Blue Shield** ____________________
- ❑ **HealthKeepers, Inc.** ____________ **(HMO)** ❑ **Priority Health Care, Inc.** ____________ **(HMO)**
- ❑ **Peninsula Health Care, Inc.** ____________ **(HMO)**

Coverage Option
If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem Blue Cross and Blue Shield or by another carrier.

2. REASON FOR APPLICATION (Check as many as apply)

- ❑ Initial enrollment
- ❑ Annual open enrollment
- ❑ Add dependent
- ❑ New hire
- ❑ Rehire – Date of rehire: ____________
- ❑ COBRA – Qualifying Event: ____________
  Event Date: ____________
- ❑ Birth of child
- ❑ Adoption or placement for adoption (attach legal documentation)
  Date of adoption/ date of placement for adoption: ____________
- ❑ Marriage
  Date of marriage: ____________
- ❑ Loss of other coverage
  Date previous coverage ended: ____________
- ❑ Medical child support order (attach legal documentation)
  Date of order: ____________
- ❑ Appointment of Legal Guardian
  Effective date of appointment: ____________
- ❑ Other (please specify): ____________

3. TYPE OF COVERAGE/PLAN

Health Coverage
- ❑ Employee Only
- ❑ Employee and Spouse
- ❑ Employee and One Child
- ❑ Employee and Children
- ❑ Employee and Family

Vision Coverage
- ❑ Voluntary Vision

(type of coverage must match health coverage)

4. EMPLOYEE INFORMATION* (Please refer to Definitions of Eligibility, Section 9)

**If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name and PCP number.*

Social security #	Date of birth (MM/DD/YYYY)	Sex: ❑ M ❑ F
Last name	First name	M.I.
Street address		Apt. #
City	State	Zip
Daytime phone (with area code)	Evening phone (with area code)	
Anthem PCP name* (please provide first and last name)		
Anthem PCP ID number*	Current patient? ❑ Yes ❑ No	

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
Anthem Blue Cross and Blue Shield and its affiliated HMOs, HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

[illegible]

Request for Redetermination of Medicare Prescription Drug Denial

Because we, Anthem Senior Advantage Value (HMO), denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
4361 Irwin Simpson Rd
Mailstop: OH0205-A537
Mason, OH 45040

Fax Number:
1-888-458-1406

You may also ask us for an appeal through our website at www.anthem.com/medicare.
Expedited appeal requests can be made by phone at 1-800-467-1199, (TTY users can call 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name ______________________ Date of Birth ____________

Enrollee's Address ________________________________

City ________________ State ________ Zip Code ____________

Phone ____________________

Enrollee's Plan ID Number ________________

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name ________________________________

Requestor's Relationship to Enrollee ____________________

Address ________________________________

City ________________ State ________ Zip Code ____________

Phone ____________________

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare 24 hours a day, 7 days a week.

Y0071_12_14024_U_012 File & Use 12/21/2011

What is the alpha prefix for anthem bcbs.

Last revision: 9/19 Operations. We notify you if we deny your request to a restriction. His â € œAdaúde Protected Information is meant any information from written and oral health about you, including demigraphing data that can be used â € â € œ to identify it. V. You can repeal your authorization in writing at any time, except as we act in confidence in the authorization. For law enforcement purposes. If the installation change this warning, we will publish a notification at each place of the office and will provide a copy of the revised warning on our site. You have the right to request a review of this decision. The installation may disclose your health information to meet the worker's compensation laws or similar programs. Contact Person The contact person in the installation for all problems in relation to patient privacy and their rights under the federal patterns of privacy is the privacy officer. Under certain circumstances, we can close our agreement with a restriction. Information on issues covered by this warning may be requested by contacting the Privacy Officer. Depending on the circumstances, you may have the right to have the decision to deny revised access. We can deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access probably requested in danger in danger your life or safety or that of another person, or is probably which will cause substantial damage to the other person referenced in information. You can oppose these disclosures. If our installation maintains psychotherapy notes, we will require your written authorization for the use or disclosure of psychotherapy notes that are not by the creator of these notes, by the installation of your training programs or the installation to defend yourself in a legal action moved by you. You can ask us to use or disclose certain parts of your informations of saples protected for the Treatment operation, payment and media assistance. This right applies to disclosures for other purposes that are not treatment, payment or medical assistance operations, as described in this privacy notice. We encourage you to express any worries that may have in relation to the privacy of your information. You will not be retaliated in any way by registering a complaint. 4. We will not require you to provide an explanation for your request. III. Your request must declare the specific restriction requested and to whom you want the restriction to apply. The installation is not obliged to agree with a restriction that you can request, unless your request related to a disclosure to a healthy plan for items or Services that have been paid in the choice for you or someone who is not the health plan and the disclosure is not required by law. You can ask us not to register a claim to your health plan if an agreed value is paid. We are also obliged to provide you with this privacy notice of our Functions and Privacy Practices. Requests must be made in writing to our privacy officer using the contact information below. Uses and disclosures allowed without authorizations, but with opporutnity to object, we can disclose your health information protected to your family member if it is directly relevant to the person's involvement in your care or payment related to your care . Uses and disclosures in addition to the treatment, payment operations and permitted administration or opportunity to object to federal privacy rules allow us to use or disseminate their protected health information without their Permission or authorization for several reasons, including the following: when necessary legally. VIII. We can also disclose your information related to the attempt to locate or Members of Famãlia or others involved in their care about their location, condition or death. In this request in writing, you must also provide a reason reason Support the requested change. To inspect and copy your information information, you must send a written request to the privacy officer whose contact information are listed in the last page of this privacy notice. In the case of a series threat to health or safety. Specified government functions. For the worker's compensation. The disclosures of their saved information for purposes described in this privacy notice can be made in writing orally or by fac-smile. We can use or disseminate your protected health information, as necessary, for our own health operations to facilitate the function of Spine & Orthopedia geogger and to provide quality care to all patients. Other uses and disclosures. This is the health information that is created or received by your health care provider, and which relates to your physical or mental health or future or condition. Uses and disclosures of protected health information 1. We can condition this accommodation asking for information on how payment will be treated or specification of an alternative address or other contact method. If you do not oppose these disclosures, in the exercise of our professional judgment, that is of your interest in order to make the disclosure of directly relevant information for the involvement of this person with your CAUTION, we can disclose your protected health information as described. You can request a restriction by contacting the privacy officer using the contact information below. Ã €overs, we will provide a paper copy of this warning, even if you have already received a copy of the notice or agreed to accept this electronic warning. Applications for changes should be in writing and should be directed to our privacy officer whose contact information are listed in the last pages of this of privacy. Its informação µs protected from Saúdde Serão used, such as For payment for the services we provide. We will use and disclose your protected health information to provide, coordinate or manage your attention to health and any related services. Payment. Right to receive accounting. Our duties The installation is required by law to maintain privacy or health information and report on you any violation of protected health information not guaranteed. The right to request to receive confidential communications from us by alternative means or an alternative location. You have the right to request an accounting of certain disclosures of your health protected information made by the installation. We reserve the right to change the terms of this notice and to make the new warning provisions effective for all future protected health information we maintain. To report suspicions of abuse, neglect or domestic violence. To conduct health survey activities. Uses and disclosures that you authorize this above, we will not disclose your health information that is not with your written authorization. As part of the treatment, payment and health care operations, we can also use or disclose your protected health information. We will provide the first accounting that you will request in any 12-month without charge, subsequent container requests may be subject to a reasonable cost-based fee. The right to obtain a paper copy of this notice. You have the right to request that we communicate with you of certain ways. The request for accounting must be made in writing to our privacy officer. Right to request amendments to their protected health information. The request must specify the time sought for accounting. Saw. This privacy notice describes how we can use and disseminate your health information To perform treatment, payment or medical assistance operations and for other purposes that are allowed or required by law. You can complain The installation by contacting the privacy officer verbally or in writing, using the contact information below. Uses and disclosures of protected health information - organizations can use their protected health information for treatment purposes, obtaining payment for treatment and fulfillment of health operations. We specifically require your written authorization for marketing or selling your protected health information. Protected health information may be used or disclosed only for those purposes unless the installation has obtained its authorization, or the use or disclosure is allowed by the regulations of HIPAA privacy or state law. If the installation agrees with the requested restriction, we can not use or disseminate your protected health information, violating this restriction unless it is necessary to provide treatment emergency. Vii. According to federal law, however, you can not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation or for use in a civil, criminal or administrative process; and protected health information that are subject to a law that proceeds to access to protected health information. If you think your privacy rights have been violated by this installation, you can send a complaint to: Georgia Spine & Orthopedics Attn: Privacy Officer 11650 Alpharetta Hwy, Suite 100, Roswell, GA 30076 Phone: 404-596 -5670 Anonymous Hotline ::Drix In Independence Avenue, S.W., Washington, D.C. 20201, or calling for 1-877-696-6775. II You can inspect and get a copy of your protected outgoing information contained A set of records designated while we maintain the protected health information. You can also That we do not disclose your health information to family members or friends who may be involved in their care or for notification purposes, as described in this privacy notice. For search purposes. If information in a set of significant records is maintained electronically, you can request an electronic copy in a form and format of your choice that is readily produced or, if the format / format It is not readily produced, you will be given a legal electronic copy in a hatable time not to exceed 60 days. Compligents that you have the right to express complaints for the installation and the secretary of health and human services, if you believe that your privacy rights have been violated. We are also not obliged to explain the disclosures that you requested, disclosures that you agreed to sign a formulation of authorization, disclosures for a directory of installations, for Friends or relatives involved in their care, or certain other disclosures that we have permission to do without their authorization. A set of records meanings Ã ¢ â € "Contemplation and billing records and any other records that your surgeon and installation use to make decisions about you. Security Policy This notice privacy is being supplied to you as a requirement of a federal law, the Law of Portability and Liability of Saúde Insurance (HIPAA). Let's accommodate reasonable requests. If we deny your request for change , you have the right to present a statement of disagreement with us and we can prepare a refutation for your statement and will provide a copy of such refutation. You can request an alteration Of Saúde Protected Information on You in a Designated Registry Set, as long as we maintain this information. Your right has the following rights on your health information: "Right to inspect and copy protected health information. When there is risks to the publicity of the bullshit. The right to request a restriction on and disclosures of their protected health information. Your request can be denied if we do not create Phi, if the amendment is not part of the normal maintenance of Phi records, and if the change is never included for inspection by any other group or party and if we believe that the registration is accurate and complete without the change. We are obliged to comply with the terms of this warning, as can be changed from time to time. If you request a card of your information, we may charge a fee for the costs of cerefy, correspondence or other costs incurred by us in accordance with your request. CONTACT OUR MOTHER CUSTODIAN RECORDS IF YOU HAVE LATERY ADVICE TO THE ACCESS TO YOUR MOTHER REGISTRATION. It also describes your rights to access and control your protected health information in some cases. Contrary requests may not be made by periods of time more than six years. In connection with court and administrative proceedings. A treatment. A treatment.

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