HEALTHYCT
YOUR HEALTH — YOUR PLAN.

Prior Authorization Request Form

Member Name:	**Member ID#:** **Member DOB:**
Name of Requesting Provider: **City/State:**	**Name of Rendering Provider/Name of Service Location:** **City/State:**
Requesting Provider NPI#:	**Rendering Provider/Service Location NPI#:**
Requesting Provider Tax ID#:	**Rendering Provider/Service Location Tax ID#:**
Requesting Provider Contact Name:	**Date of Service:** ☐ **Inpatient** ☐ **Outpatient**
Requesting Provider Contact Phone # and Ext.	**ICD Code(s)** ****ICD10 only for services 10/1 or later****
Requesting Provider Contact Fax #:	**CPT Code(s):** **HCPCS Code(s):**

DME/Prosthetics:	**Potentially Cosmetic Procedures:**
☐ Hospital Bed (and mattress)	☐ Blepharoplasty/Brow Ptosis Repair
☐ Custom Wheelchair	☐ Breast Reduction Surgery
☐ Prosthetic limbs; whole limb or part of limb	☐ Breast Reduction/Mastopexy
Other:	☐ Breast Repair/Reconstruction (not following mastectomy)
☐ Ambulance: Non-Emergent Air & Ground	☐ Breast Augmentation
☐ Clinical Trials	☐ Canthoopexy/Canthoplasty
☐ Experimental/Investigational Procedures	☐ Cervicoplasty
☐ Genetic Testing (Breast, Ovarian, Colorectal CA)	☐ Chemical Peels
☐ Laser Tx for Cutaneous Vascular Lesions	**Radiology: A L L**
☐ Orthognathic/Jaw Surgery	☐ i.e., CT, MRI/MRA, SPECT, PET & Nuclear Cardiology
☐ Prosthetics (whole or part limb)	
☐ Sleep Studies (other than in the home)	
☐ Spinal Surgery (Inpt and Outpt)	
☐ TMJ Surgery	
☐ Septoplasty/Rhinoplasty	
☐ Repair of Vestibular Stenosis	

Submit Form with Supporting Medical Necessity Documentation to Prior Authorization

FAX # 1(855)817-5696

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Instructional Information for Prior Authorization

If you do not have access to a fax machine, to properly facilitate your request, please mail this form to:

HealthyCT – 35 Thorpe Avenue, Suite 104 – Wallingford, CT 06492
Attn: Prior Authorization

The Following Inpatient Services also require Prior Authorization:

- Medical/Surgical Inpatient Admission
- Skilled Nursing facility Admission
- Acute Inpatient Rehabilitation
- Sub-Acute Care Admission
- Inpatient Hospice
- Acute Behavioral Health Admissions
- Behavioral Health Partial Hospitalization
- Residential Treatment Facilities

Please contact HealthyCT at least 15 business days in advance for planned admissions and within 24 hours of any urgent admission at: 1(855)458-4928

Individual forms are required to authorize the following:

- Behavioral Health Services: Autism Services, Biofeedback, Neuropsychological Testing, Psychological Testing, Intensive Outpatient Program (IOP)
- Home Health Care (including initial evaluation)
- Home IV Infusion Therapy
- Infertility Treatments
- Physical Therapy /Occupational Therapy and Habilitative Services (after the first 10 visits per episode) – please provide copy of initial evaluation with request
- Applied Behavioral Analysis
- Out of Network Services (only when requesting in-network level of coverage)

HealthyCT requires Notification for the following:

- Maternity after First Pre-Natal Visit
- Birth to Three Program
- Dialysis