Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care

# *Precertification Request*

**Please check the appropriate box below and send only the corresponding authorization type to that fax number. You can also submit your request online through Availity:* https://mediproviders.anthem.com/nv/pages/home.aspx.**

☐ For durable medical equipment (DME), outpatient rehabilitation (physical therapy/occupational therapy/speech therapy), pain management, home health services (including IV infusion nursing), hyperbaric treatment and wound care, please fax to: **1-866-920-8362**.

☐ For all other precertification requests (including all elective inpatient or outpatient services), please fax to: **1-800-964-3627**.

☐ Phone: **1-844-396-2330** (to speak with someone for assistance/referral status update)

☐ If expedited, please explain:_____

Date: _____ Provider return fax: _____

| **Member information** | | |
|---|---|---|
| First name: | Last name: | Member ID: |
| Address: | City, state, ZIP: | |
| DOB: | Phone: | |
| Additional member information: | | |
| **Referring provider** ☐ **Participating (PAR)** | ☐ **Nonparticipating (NONPAR)** | ☐ **In credentialing process** |
| Full name: | Specialty: | |
| Office contact name: | Office phone: | Office fax: |
| Address: | City, state, ZIP: | |
| **Servicing facility** ☐ **PAR** | ☐ **NONPAR** | ☐ **In credentialing process** |
| Name: | | |
| NPI: | Provider ID: | TIN: |
| Facility contact name: | Facility phone: | Facility fax: |
| Address: | City, state, ZIP: | |

| **Requested service (For type of service, check all that apply.)** |
|---|
| Date/date range of service: |
| ICD-10 code(s): |
| CPT® code(s) or description of service(s) if CPT code not available (include requested units): |
| Type of service: ☐ Outpatient ☐ Inpatient<br>☐ Pain management ☐ DME ☐ Diagnostic study ☐ Outpatient rehab ☐ Office visit<br>☐ Personal care services ☐ Home health (OT/PT/ST/skilled nursing/home health aide)<br>☐ Infusion pump ☐ IV supplies ☐ IV infusion nursing ☐ Other: |
| Place of service: ☐ Hospital ☐ Ambulatory surgery center ☐ Office ☐ Home ☐ Independent lab ☐ Nursing facility ☐ Other: |
| Additional information: |

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization, provide the authorization number.

**Disclaimer:** Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to Anthem Blue Cross and Blue Shield Healthcare Solutions claims payment policy and procedures.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

**https://mediproviders.anthem.com/nv**


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