Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care

Provider Bulletin
October 2022

Prior authorization and notification requirements

How to request prior authorizations and give us notifications:

- Online: **https://providers.anthem.com/nv** then log in to the Availity*
- By phone: **844-396-2330**
- By fax: **800-964-3627**
- **For behavioral health requests**, they should be submitted using our preferred electronic method at **availity.com**.
    - If you prefer to paper fax, submit behavioral health **outpatient** information to **844-442-8007**; fax behavioral health **inpatient** information to **844-451-2794**.

Verify authorization requirements for specific codes/services:

- Visit **https://providers.anthem.com/nv**.
- Select ***Resources*** from the top menu.
- Then select ***Precertification lookup tool***.
- Select **Prior Authorization & Claims** from the menu.

* Requirements listed are for network providers. In many cases, out-of-network providers may be required to request prior authorization for services when network providers do not.

Prior authorization — the act of authorizing specific services or activities before they are rendered or occur.

Notification — telephonic, fax, or electronic communication received from a provider to inform us of his or her intent to render covered medical services to a member:

- Give us notification prior to rendering services outlined in this document.
- For emergency or urgent services, give us notification within 24 hours or the next business day if a member is admitted.
- There is no review against medical necessity criteria; however, we verify member eligibility and provider status (network and non-network).

Peer-to-peer discussion — If the medical director denies coverage of the request, the appropriate notice of action (including the member's appeal rights) will be mailed to the requesting provider/member's PCP and/or attending physician and member. Providers have the right to discuss this decision with a medical director **within 30 calendar days** from receipt of the initial denial by calling the local health plan at **844-396-2330**, Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

Appeals – Providers can file an appeal **within 60 calendar days** from receipt of the initial denial. The appeal will be looked at by someone who did not make the original decision and does not report to the person who made the original decision. Please see bulletin ***Important information about your appeal rights as a provider*** for details on how to file an appeal.
https://providers.anthem.com/docs/gpp/NV_CAID_AppealRightsasaProvider.pdf?v=202208031456

What if I need help?

If you have questions about this communication or need assistance with any other item, call Provider Services at **844-396-2330** for immediate assistance. Otherwise use the ***Contact Us*** feature on our website to submit an inquiry to our Provider Experience team. All inquiries will be responded to within 48 hours.
https://providers.anthem.com/nevada-provider/contact-us/email

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

https://providers.anthem.com/nv

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