Alliance Health Prior Authorization Request Cover Sheet

Date of submission (dd/mm/yyyy) _____

To: Alliance Health Utilization Management Department

Client/member name _____

Agency name _____ Agency contact person _____

Contact phone number _____ Contact person role _____

Contact email _____

Documents attached (please list):

Additional comments:

Please email all requests and accompanying documents (including cover sheet) to umoutofnetwork@AllianceHealthPlan.org.

Total number of pages (including cover sheet) _____

Prior Authorization Request Form

For faster, self service: AllianceHealth.okta.com.

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be NC Medicaid eligible on the date of service or date of service date the equipment or prosthesis is received by the beneficiary.

For prior authorization, notifications, and concurrent review:
Fax 919-651-8691
Email umoutofnetwork@AllianceHealthPlan.org

See reverse side for instructions

I. Agency information

1. PHP name	2. Beneficiary/recipient name (last, first, M.I.)	3. Date of birth (mm/dd/yyyy)
4. Address (street, city, state, postal code)		5. NC Medicaid ID number/CNDS number

6. Diagnosis code	7. Diagnosis description

8. Name and address of facility where services are to be rendered, if other than home or office

II. Service information

9. Select one of the following:
- Behavioral health request ☐
- Physical health request ☐

And select request priority:
- Standard request ☐
- Expedited request ☐

Care setting:
- Inpatient ☐
- Outpatient ☐

10. Ref No.	11. Procedure code	12. Description of service/item	13. Start date	14. End date	15. Qty or units
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

16. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis. (Attach additional pages if necessary.)

III. Billing entity (provider/agency/facility)		IV. Requesting entity (provider/agency/facility)	
17. Provider name	18. NPI ☐☐☐☐☐☐☐☐☐☐	22. Provider name	23. NPI ☐☐☐☐☐☐☐☐☐☐
19. Mailing address (street, city, state, postal code)		24. Mailing address (street, city, state, postal code)	
20. Phone	21. Fax and email	25. Phone	26. Fax and email

By submitting this form, the provider identified in this Section III. certifies that the information given in the Section I, II and III of this form is true, accurate, and complete.

Instructions for completion

I. Agency information - To be completed by the provider requesting the prior authorization

1. Prepaid health plan (PHP) name - Enter "Alliance Health", the PHP in which the beneficiary/recipient is enrolled or receiving services. (PHP refers to Standard & Tailored Plans)
2. Beneficiary/recipient name - Enter the beneficiary/recipient name. If the individual has Medicaid, enter their name as it appears on the NC Medicaid identification card.
3. Date of birth - Enter the beneficiary/recipient date of birth.
4. Address - Enter the beneficiary/recipient address, city, state, and zip code.
5. NC Medicaid number or Common Name Data Service (CNDS) number - Enter the beneficiary/recipient NC Medicaid Identification number as shown on the NC Medicaid identification card or county letter of eligibility, or the CNDS number.
6. Diagnosis code - Enter the diagnosis code(s).
7. Diagnosis description - Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
8. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. Service information

9. Select one of the following for Alliance non-delegated services: behavioral health request or physical health request. - Select the type of request that is most appropriate. Select the request priority: standard or expedited request. Select the care setting: inpatient or outpatient. Select the most appropriate response.
10. Ref. No. - (Reference number) a unique designator (1-12) identifying each separate line on the request.
11. Procedure code - Enter the procedure code(s) for the services being requested.
12. Description of service/item - Enter a specific description of the service/item being requested.
13. Start date - Enter the from date that services will begin if authorization is approved (mm/dd/yyyy format).
14. End date - Enter the through date that services will terminate if authorization is approved (mm/dd/yyyy format).
15. Qty or units - enter the quantity or number of units.
16. Detailed explanation of medical necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. For behavioral health services, attach current comprehensive clinical assessment (CCA), diagnostic assessment (DA), and other clinical or psychiatric evaluations. For state-funded requests for intellectual/developmental disability (I/DD) services, attach the North Carolina Support Needs Assessment Profile (NC SNAP). For substance use disorder (SUD) services, attach American Society of Addiction Medicine (ASAM) Level of Care determination. For physical health services, attach history and physical, progress notes, supporting clinical documentation notes and any applicable required forms. These items should be submitted as required by service definition.

Do not use another Prior Authorization Form.

III. Provider requesting prior authorization

17. Provider name: Enter the requesting provider information. If a clinic or group practice, also complete section IV.
18. National Provider Identifier (NPI): Enter the requesting provider NPI.
19. Address: Enter the complete mailing address in this field.
20. Telephone: Enter the requesting provider's telephone number.
21. Fax and email: Enter the requesting provider fax number, including area code, and email address.

IV. Prescribing/performing practitioner

This section must be completed for services which require a prescription such as durable medical equipment, physical therapy, or for services which will be prescribed by a physician/practitioner that require prior authorization, or when the provider in section III is a clinic or group practice. Check your provider manual for additional instructions.

22. Name: Enter the name of the prescribing/performing practitioner.
23. Telephone number: Enter the prescribing/performing practitioner's telephone number including the area code.
24. Address: Enter the address, city, state, and zip code.