FirstMedicareDirect

FIRSTCAROLINACARE INSURANCE COMPANY

PRIOR AUTHORIZATION REQUEST

Please fax to 816-313-3060

SECTION 1

TODAY'S DATE: /____/______ ADMIT/PROCEDURE DATE: /____/_____ # VISITS/DAYS REQUESTED __________

PERSON COMPLETING FORM:________________________ PHONE #_____________ FAX # ______________________

SECTION 2 – MEMBER/PATIENT INFORMATION

NAME:____ DOB: ______________________

MEMBER ID# __________________________

SECTION 3 – ORDERING PROVIDER

NAME:____ TAX ID #: __________________________

PHONE # __________________________________ NPI #: ___________________________

SECTION 4 – PLACE OF SERVICE

NAME:____ TAX ID #: __________________________

DIAGNOSIS:____ICD 10- CODES: ____________NPI #: __________________

PROCEDURE____ CPT CODES: ____________INPT_______OUTPT_______

SECTION 5 – SERVICES REQUESTED

Inpatient Services

____ Inpatient Hospitalization
____ Rehab
____ SNF
____ Behavioral Health
____ Transplant (Organ, Bone Marrow, Stem)

Outpatient Services

____ Genetic Testing
____ Drugs on the PA List

____ DME/Prosthetics/Orthotics
PA required for purchased items $1,000.00 or more and all DME rentals
DME Item Name ______________________________________
HCPCS Codes____
Prosthetics ____
Orthotics ____

Out of Network Referral

____ HMO/HMO Plus Member
____ PPO Members for services requiring PA

SECTION 6 – CLINICAL INFORMATION

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For questions or additional information, please call 844-201-4957 (Option 3, then 2)

For FCCI Use Only Authorization # ____________________ FirstMedicare Direct Contact_____________________

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