PART B MEDICATION REQUEST FORM

Submit this completed form by fax to **1-833-610-2399,** or on our provider portal:
https://secure.healthx.com/NHCAdvantage.Provider
Call 1-844-854-6886 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless it is an emergency, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐Routine/Standard ☐ Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION		
Member Name:		Member ID:
Date of Birth:	Member Living Facility:	
REQUESTING PROVIDER/FACILITY		
Requestor's Name (Print):	Phone Number:	Fax Number:
Referring Provider (If other than requestor):	Referring Provider: ☐NP/PA ☐PCP ☐Therapy Rep ☐Other	
NPI/PIN number:	Date of Request:	
SERVICING PROVIDER/FACILITY		
Admitting/ Servicing Facility/ Provider Name:		
NPI/ PIN Number:	Phone Number:	Fax number:
Address:		
City:	State:	Zip:
MEDICATION REQUESTED		
☐Initial Request ☐ Extension Request, Previous Auth #:		
Place of service: ☐ Home Infusion ☐Office ☐ Outpatient Hospital ☐ Specialty Pharmacy		
Specialty Pharmacy:	Home Infusion:	
Days/ Visits/ Units Requested:	Date of Service:	
HCPCS Code(s):	CPT/Other billing code:	
Drug requested:	NDC:	
Dosage:	Frequency/Duration:	
Current Primary Diagnoses and ICD-10 Code (s):		

CLINICAL INFORMATION
• Please submit written documentation from the medical record to support the procedure, including photos when applicable. • Missing this information may delay the decision on your request or may result in Lack of Information denial. • Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, et
OUT-OF NETWORK SERVICES ONLY
• Has the service been scheduled already? ☐Yes ☐No • Is this a specialized service that no other In-network provider can render? ☐Yes ☐No • Does the member have an established relationship with the provider that should not be interrupted? ☐ Yes ☐No If “Yes”, explain (include last visit date):

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