

Avoid Processing Delays for Prior Authorization Requests with These Guidelines

FOLLOW SUBMISSION INSTRUCTIONS AND HELP IMPROVE PATIENT EXPERIENCE WITH TIMELY CARE

Set expectations with your patients to help them understand how the prior authorization (PA) process and timelines work when a PA is needed.

Physicians and other providers can coordinate medically necessary care for their patients with a PA form that is submitted timely and with accurate information.

Where to submit PA requests

For elective inpatient or outpatient services, physicians and other providers:

- **Affiliated with a delegated participating physician group (PPG)** – follow the PPGs PA procedures and contact the PPG for information.
- **Contracting directly with Wellcare By Health Net (WCBHN) fee for service (FFS)** – obtain PA from the Utilization Management Department or as specified on the Prior Authorization Requirements lists. Go to bit.ly/HNPAInfo to view the lists.



Be aware of PA timelines

For elective inpatient or outpatient services, submit requests for PA:

- ✓ As soon as the need for service is identified, or
- ✓ At least five business days for routine requests, or
- ✓ 72 hours for urgent requests. Emergency services do not require prior authorization.

Avoid PA processing delays

Here are the most common reasons why PA forms are returned or not processed.

- ⊗ Not submitted timely.
- ⊗ Lack of sufficient clinical notes. Some surgical requests (e.g., reconstructive surgery or repair) require submission of non-returnable color photos, models or X-rays.
- ⊗ Incorrect CPT codes.
- ⊗ Missing anticipated date of service, if scheduled.
- ⊗ Missing the tax identification number/National Provider Identifier (NPI) for referring and servicing provider(s).
- ⊗ Sent to an incorrect department and/or entity.
- ⊗ Amount requested is missing or incorrect (number of visits, dosage, quantity).

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Use online tools to help prepare for PA request submission

- Verify member eligibility – Log in to the provider portal at **bit.ly/HNProviderPortal**.
- Confirm benefit coverage – The member's Evidence of Coverage is available online at **bit.ly/WCBHN-EOC**.
- More details about PA – Go to **bit.ly/HNPAInfo**. Select *Medicare – California* under Prior Authorization Lists.
- Prior Authorization Validation Tool – Under Online Prior Authorization Validation Tool, use the tool for Medicare Plans at **bit.ly/HNPAInfo**.



Fill out a PA form

You can find PA forms:

- In the Provider Library at **bit.ly/ProvLibrary**. Choose *Medi-Cal*, go to *Forms and References*, then select the *California Medi-Cal Prior Authorization (CalViva Health) (PDF)* form under 'I' for Inpatient or 'O' for Outpatient based on services needed.
- On the provider portal at **bit.ly/HNPAInfo**. Select *CalViva Health – Prior Authorization Request Form – Outpatient or Inpatient* under Prior Authorization Request Form.



Include required information

The PA Requirements form must be completed in its entirety. It must also include sufficient clinical information and/or medical records to support medical necessity for services that are requested.

Be sure to include:

- Member's name.
- Member's identification number.
- Member's date of birth.
- Diagnosis (clinical notes, reports of previous procedure, specialist reports/evaluation).
- Requesting physician's name, address, phone and fax numbers, and contact person.
- Place where services are provided.
- Physician's name (physician receiving the referral), ancillary provider name and facility name.
- Procedures codes.
- Date of service.



Submit the PA form to the plan

- Online post login via the provider portal at **bit.ly/HNProviderPortal**.
- Fax the PA form to the Medical Management Department. Use the fax number on the form to submit requests 24 hours a day, seven days a week.
- The Plan has partners for select PA reviews. Refer to the Prior authorization contact section on where to submit your PA requests.

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Find the status of your PA

We encourage you to frequently check the status of submitted authorizations by referencing the list below or post login on the provider portal at **bit.ly/HNProviderPortal**.

Decisions are made within 5 business days for routine requests and 72 hours for urgent requests (unless additional information is needed to determine whether, or to what extent, the benefits are covered or payable under the member's plan).

If you have not received a response within this timeframe, please contact the Plan.

Prior authorization contacts

Listed below are contact numbers for requesting PA. Also included is contact information for commonly requested departments and preferred partners that may receive PA requests.

Contacts	
Prior authorization request	Employer group 800-977-7282; fax:800-793-4473 Online submission: provider.healthnet.com
	Individual and Special Needs Plan (SNP) (does not apply to employer groups) Fax: 844-501-5713 Online submission: provider.healthnetcalifornia.com
Hospital Notification Unit/Post Stabilization Notification	800-995-7890
Hospital Notification Unit	Employer group 800-995-7890; fax: 800-676-7969
	Individual and Special Needs Plan (SNP) (does not apply to employer groups) Fax: 844-825-8045
Health Net Provider Services (for provider status, member eligibility and benefits, member EOC inquiry)	provider.healthnet.com ; 800-929-9224
MHN (behavioral health provider)	844-966-0298
Pharmacy Department	800-548-5524; fax: 800-977-8226
Apria Healthcare (CPAP and BiPAP)	800-277-4288
AcariaHealth (preferred hemophilia provider)	844-515-0163; fax: 844-750-0827
Coram Specialty Infusion Services (preferred home infusion provider)	866-899-1661; fax: 866-843-3221
American Specialty Health Plans, Inc. (ASH Plans)	800-678-9133; www.ashlink.com
Transplant Team	Fax: 833-769-1143