New Mexico Uniform Prior Authorization Form

PRESBYTERIAN

To contact the coverage review team for Presbyterian Health Plan, please call between the hours of 8:00am – 5:00pm. For after-hours review, please contact 505-923-5757.

Department	Fax #	Phone #	To file electronically, send to
Prior Authorization	505-843-3047	505-923-8469 or toll-free at 1-866-597-7835	https://www.phs.org/providers/resources/Pages/portals.aspx
Pharmacy	1-800-724-6953/1-505-923-5540	505-923-5757, option 3	https://www.phs.org/providers/authorizations
Inpatient UM	505-843-3107	1-855-594-7737	https://www.phs.org/providers/resources/Pages/portals.aspx
Home Health Care	505-559-1155/1-877-606-1155	505-923-2059 or toll-free at 1-877-606-1151	https://www.phs.org/providers/resources/Pages/portals.aspx
UNM Prior Authorization	505-843-3108	1-866-597-7835	https://www.phs.org/providers/resources/Pages/portals.aspx
Behavioral Health	Centennial Care: 505-843-3019	1-888-923-5757	Centennial Care: nmcentennialcare@magellanhealth.com
	Medicare/Comm: 1-888-656-4967		Medicare/Commercial: www.magellanhealth.com/provider
NIA Magellan (Imaging)	1-800-784-6864	1-866-236-8717	www.radmd.com

[1] Priority and Frequency

a. Standard [ ] Services scheduled for this date:

b. Urgent/Expedited [ ] Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.

c. **Frequency** Initial [ ] Extension [ ] Previous Authorization #:

[2] **Enrollee Information**

a. Enrollee name: | b. Enrollee date of birth: | c. Subscriber/Member ID #:

d. Enrollee street address:

e. City: | f. State: | g. Zip code:

[3] Provider Information: Ordering Provider [ ] Rendering Provider [ ] Both [ ]

Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.

a. Provider name: | b. Provider type/specialty: | c. Administrative contact:

d. NPI #: | e. DEA # if applicable:

f. Clinic/facility name: | g. Clinic/pharmacy/facility street address:

h. City, State, Zip code | i. Phone number and ext.: | j. Facsimile/Email:

[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 7 if drug requested)

a. Service description:

b. Setting/CMS POS Code Outpatient [ ] Inpatient [ ] Home [ ] Office [ ] Other* [ ]

c. *Please specify if other:

[5] HCPCS/CPT/CDT/ICD-10 CODES

a. Latest ICD-10 Code	b. HCPCS/CPT/CDT Code	c. Medical Reason

[6] Frequency/Quantity/Repetition Request

a. Does this service involve multiple treatments? Yes [ ] No [ ] If "No," skip to Section 7.

b. Type of service: | c. Name of therapy/agency:

d. Units/Volume/Visits requested: | e. Frequency/length of time needed:

[7] Prescription Drug

a. Diagnosis name and code:

b. Patient Height (if required): | c. Patient Weight (if required):

d. Route of administration Oral/SL [ ] Topical [ ] Injection [ ] IV [ ] Other* [ ]

*Explain if "Other:"

e. Administered: Doctor's office [ ] Dialysis Center [ ] Home Health/Hospice [ ] By patient [ ]