Insurance Contact List for Authorization

Insurance	Phone	Fax	Form Needed
*AARP Medicare Advantage	877-757-4440	866-322-7276	Texas Standard Prior Authorization
* AARP Secure Horizon	877-757-4440	866-322-7276	Texas Standard Prior Authorization
* Aetna/CHIP Medicaid	800-306-8612	866-835-9589	Texas Standard Prior Authorization
*Aetna Medicare 800-624-0756	Must Call Plan	Must Call Plan	Texas Standard Prior Authorization
*Ambetter	877-687-1196	855-537-3447	Texas Standard Prior Authorization
*Amerigroup/CHIP Amerigroup	713-218-5151 ext . 35889	866-249-1271	Amerigroup/CHIP Amerigroup Form
*Amerigroup-Integranet	281-591-5289	281-405-3431	Integranet Portal
*Baylor Scott and White	888- 316-7947	800- 626-3042	Texas Standard Prior Authorization
*Blue Cross/Anthem Medicare	855-878-1785 ext. 35278	888-235-8468	Texas Standard Prior Authorization
*Blue Cross BS Medicaid	888-292-4487	855-879-7180	Texas Standard Prior Authorization
*Bright Healthcare	844-926-4525	877-438-6832	Texas Standard Prior Authorization
*Blue Cross Blue Shield	Must call plan	Must call plan	Texas Standard Prior Authorization
*Care N Care	855-359-9999	888-965-1964	Texas Standard Prior Authorization
*Children's Medical Center	800-947-4969	214-861-5510	Texas Standard Prior Authorization
*Cigna Healthspring Medicaid	877-562-4402	877-809-0787	Texas Standard Prior Authorization
*Cigna Healthspring Medicare	800-280-8888	Must Call Plan	Texas Standard Prior Authorization
*Cook Children/CHIP Cook	800-862-2247	682-885-8402	Texas Standard Prior Authorization
*Driscoll Medicaid	877-324-3627	866-741-5650	Texas Standard Prior Authorization
*First Care Medicaid	800-431-7798	800-248-1852	Texas Standard Prior Authorization
* Humana Gold Plus (HMO)	877-757-4440	866-322-7276	Texas Standard Prior Authorization
*Medicaid TMHP/CHIP	800-540-0694	512-514-4205	TMHP Form
*Molina Medicaid	866-449-6849	866-420-3639	Texas Standard Prior Authorization
*Molina Medicare MMP	866-448-6849	844-251-1451	Texas Standard Prior Authorization
*Parkland Medicaid	800-306-8612	800-240-0410	Texas Standard Prior Authorization
*RightCare Scott & White	855-897-4448	512-383-8703	Texas Standard Prior Authorization
*Scott and White	888-316-7947	800-626-3042	Texas Standard Prior Authorization
*Superior Medicaid	877-391-5921	844-560-8993	Texas Standard Prior Authorization
*Superior Medicare (MMP)	800-218-7508	877-808-9368	Texas Standard Prior Authorization
*Tricare Prime	800- 444-5445	877- 548-1547	Texas Standard Prior Authorization
*UHC Community Medicaid	866-331-2243	877-940-1973	Texas Standard Prior Authorization
*United Healthcare Dual Plan	877-757-4440	866-322-7276	Texas Standard Prior Authorization
*Wellcare	855-538-0454	877-894-2034	Texas Standard Prior Authorization
*Wellmed	877-757-4440	Call only	Call only

Texas Standardized Instruction Sheet

Section 1: Add insurance name, fax number and date of request
Section 2: Non-urgent and initial request
Section 3: Patient information (Note: Insurance ID number is required)
Section 4: Facility and contact person information with signature
Section 5: Start date and end date for all lines (Should be date of transport)

- Units for each procedure code are required
    - BLS A0428
    - ALS A0426
    - SCT A0434
    - Mileage A0425
    - ALS Disposable A04398
    - BLS Disposable A0382
    - Oxygen A0422
- Diagnosis and ICD code required

Section 6: Reason why the ambulance is required and destination of transport.

- After faxing the request with supporting clinical documentation to the Insurance company, forward all documentation to MedStar at: (817) 632-0537. Be sure to include the Fax Confirmation receipt.

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0115

Texas Department of Insurance

Please read all instructions below before completing this form.

Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: When an issuer requires prior authorization of a health care service, use this form to request authorization **by fax or mail**. An issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, via the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I. An issuer may have already entered this information on the copy of this form posted on its website.

Section II. Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV.

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI.

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: *Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before faxing or mailing your request.*

If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	Sex: ☐ Male ☐ Female ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		**Service Provider or Facility**	
Name:		Name: Metropolitan Area EMS Authority Tax ID 75-2234266	
NPI #:	Specialty:	NPI #: 1710981774	Specialty: Ambulance
Phone:	Fax:	Phone: 817-923-3700	Fax: 817-632-0537
Contact Name:	Phone:	Primary Care Provider Name *(see instructions)*:	
Requesting Provider's Signature and Date *(if required):*		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	**Code**	**Start Date**	**End Date**	**Diagnosis Description (ICD version___)**	**Code**
BLS non-emergency base	A0428				
BLS DISPOSABLE SUPPLIES	A0382				
MILEAGE	A0425				

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☑ Other: Ground Ambulance

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration:_____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) *(Medicaid only:* Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION *(SEE INSTRUCTIONS PAGE, SECTION VI)*

An issuer needing more information may call the requesting provider directly at: _____