PR 15-02

SPECIAL BULLETIN

FOR HEALTH OPTIONS PROVIDERS **JANUARY 6, 2015**

HEALTH OPTIONS (MEDICAID): SUBMITTING AUTHORIZATION REQUESTS

Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) now offers Medicaid benefits to Delawareans through Health Options. As you know, Health Options benefits were effective on Jan. 1, 2015.

Please read the following information about authorization requests closely – it could save you time and effort in the future.

BY FAX

Authorization requests should be faxed, using the *Authorization Request* form, to the Health Options Utilization Management Department at 1-855-445-4086. (This number is for **faxes only**.)

A copy of the form follows this Special Bulletin and is available online at **www.highmarkhealthoptions.com**. Select *Providers* from the menu at the top of the screen, and then choose *Transition Prior Authorization Form* under the Provider Forms section.

BY PHONE

You can also contact the Health Options Utilization Management department by phone for an authorization at 1-844-325-6254. Please keep in mind that as we continue to enroll and answer questions for Health Options providers and members, you may experience longer than normal wait times. The best time to call Utilization Management is early in the morning (before 11 a.m.) and in the middle of the week. We do not recommend that you call during the lunch hour (approximately noon to 1 p.m.).

Health Options – Prior Authorization Contact Information

Fax	Phone
1-855-445-4086 Please use the *Authorization Request* form, which is available under the Provider Forms section of **www.highmarkhealthoptions.com**.	1-844-325-6254 M – F, 8 a.m. to 5 p.m.

As always, we thank you for your patience and support. You may also want to reference PR 14-80, which was sent to you on Dec. 31, 2014, for more information about authorizations and continuity of care for Health Options members.

HIGHMARK® Delaware

Health Options
Highmark Blue Cross Blue Shield Delaware

Authorization Request Form
Transition/Continuity of Care

FAX to 1-855-445-4086

Please type or print.

Today's Date:	**Date of Service:** **Date of Admission (if applicable):**
Name of Member:	**Member's Health Option ID Number:**
Name of Requestor:	**Phone Number of Requestor:** **Fax number of requestor:**
Hospital Name if Applicable: **Hospital ID#:**	**Name of Doctor/Provider:** **Provider ID or NPI #:**
Diagnosis and ICD Codes:	**Procedure and CPT/HCPCS Codes:**

History / Additional Information

Note: Requests will be authorized ACCORDING TO THE Transition and Continuity of Care Plan.

- **Symptoms:**
- **Treatment:**
- **Past medical history**
- **Diagnostic labs and tests with results:**
- **Other diagnoses:**

Service Requested:

Date Service Initiated:

Previously authorized by another MCO: Y____N___
If yes, authorization expiration date:
MCO name: