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– Document to be updated quarterly –

Disclaimer: The information provided in the following draws from several sources, including discussions with insurers, and review of their policies, plan documents, and web resources. At the time of release, this document includes the most recently available information, however, this information is subject to change at any time.

Glossary of Terms

Benefits Package – The set of benefits that an insurance policy covers.

Certificate of Coverage/Evidence of Coverage – The document or documents that a member of a group insurance plan receives that includes the terms of coverage, eligibility and benefits. The certificate of insurance is different from an insurance policy. The Certificate of Coverage/Evidence of Coverage includes any associated documents such as riders and endorsements that have been made part of the policy.

Health Plan – See "Insurance Company."

In-network Provider – See "Network."

Insurance Company – The company that collects premiums and provides insurance coverage in return. An insurance company may be an HMO, commercial insurer or other entity.

Network – A group of doctors, hospitals and other health care providers contracted to provide services to insurance companies. Provider networks can cover a large geographic market or a wide range of health care services including, occupational therapy, physical therapy, and speech therapy. Insured individuals typically pay less for using a network provider. And some plans only pay for services provided by a provider in their network. Other terms for "network provider" are "in-network provider" or "participating provider." Those providers outside the network are often referred to as "out-of-network providers" or "non-participating providers."

Non-participating Provider – See "Network."

Out-of-network Provider – See "Network."

Participating Provider – See "Network."

Policy – A contract between the individual and the insurance company that provides the complete terms regarding coverage, eligibility and benefits. The policy includes any associated documents such as riders and endorsements that have been made a part of the policy.

Provider Network – See "Network."

Aetna

New York Plans Subject to the Authorization Requirements and Review by OrthoNet:

- Aetna Student Health
- Health Network Only
- Health Network Option
- HMO
- QPOS
- US Access
- Medicare Advantage Plan

New Jersey Plans Subject to the Authorization Requirements and Review by OrthoNet:

- Aetna Student Health
- Health Network Only
- Health Network Option
- HMO
- QPOS
- US Access
- Medicare Advantage Plan

Connecticut Plans Subject to the Authorization Requirements and Review by OrthoNet:

- **HMO:** Aetna Student Health, Health Network Only, Health Network Option, HMO, QPOS, USAccess, and Medicare Advantage Plan
- **Traditional:** Aetna Open Access, Aetna Student Health, Elect Choice, Managed Choice and PPO products and Traditional Choice (CMED) and Basic/Major Medical

Authorization

Is pre-authorization required for the initial Early Intervention (EI) Program Multidisciplinary Evaluation (MDE)?

No, pre-authorization is not required for the **initial** EI MDE.

However, some plans are network-based plans; except for primary care physician (PCP), direct access and emergency or urgent care services, the member must have a prior written or electronic referral from their PCP to receive coverage for all services and any necessary follow-up treatment. Certain services, such as inpatient stays, outpatient surgery and certain other medical procedures and tests, require both a PCP referral and precertification. Precertification

verifies that the recommended treatment is covered by Aetna. The PCP or other network providers are responsible for obtaining precertification for the member for in-network services.

In NY and NJ, if the referral does not come from an Aetna participating physician, coverage may not be provided. This varies based on plan type, but HMOs will not be required to pay for these services unless there is a referral from an Aetna participating physician.

After the initial evaluation, is pre-authorization required for EI services provided by an out-of-network provider?

Pre-authorization is *always* required through Aetna for OT, PT, and ST services when:

- The services are rendered by an out-of-network provider
- The services are provided in the home

Directions for Completing a Pre-Authorization Request for Non-participating OrthoNet Providers

If you are not an in-network provider, please contact the child's/family's primary care physician to start pre-certification. However, if the child/family is enrolled in an Aetna Open Choice plan, a non-participating provider may start the process. Access the Precertification Request Form for Non-Participating Providers and enter the following information:

Section A:

1. The Therapist Name and write in the name of the Agency
   For Example: Jayne J. Smith at Children Are Special
2. *The Rendering Therapist's individual NPI here*
3. The name of an individual who can answer questions about the information you are providing on this form
4. The office phone number including area code
5. The office fax number including area code—if there is more than one fax, indicate fax location
6. The date you are submitting the form

Section B:

1. The Child's Name
2. The Child's Date of Birth
3. The Child's Aetna Policy Number
4. The Child's home address
5. The Child's home telephone number with area code

Section C:

1. The Therapist's Name and the name of the Agency
   For example: Jayne J. Smith at Children Are Special
2. The Provider/Agency Phone number if you are an agency provider
3. The Provider/Agency's Location address if you are an agency provider
4. The Provider/Agency Fax number if you are an agency provider
5. The Agency's Tax ID number if you are an agency provider, your Tax ID if you are an individual provider
6. Check the appropriate box (Yes or No) to indicate whether the child has been seen before; if yes, enter the visit date for the child's last visit with you

Section D:

1. The service types provided during this visit (PT, OT, ST, etc.)
2. The Diagnosis code(s) – ICD-9/ICD-10 Codes
3. The Procedure Code(s) – CPT Codes
4. Explain why the services should be provided by this particular therapist rather than an in-network therapist--highlight the need for any essential specialized training to ensure effective treatment for the EI child if appropriate
5. Check the appropriate box (Yes or No) to indicate whether this is s a follow-up visit to an emergency room treatment. In most situations, the answer will be No. If the answer is yes, enter the child's last visit date.
6. Check the appropriate box (Yes or No) to indicate whether this visit is a follow-up to an emergency surgery that occurred within the last 90 days. In most situations, the answer will be No. If the answer is yes, enter the child's last visit date.
7. Unless the Service Coordinator attempted to assign the child an EI provider who has contracted with Aetna, Check "No" and indicate provider was assigned to provide services to this child under the EI program by the New York State Bureau of Early Intervention

Section E:

1. Insert Therapist Signature and today's date.

The Fax number for this form is**:** (859) 455-8650*

The address to mail the form is: Aetna
PO Box 1407
Lexington, KY 40512-4079

To expedite your response time, BEI recommends faxing this form*

Directions for Completing an Authorization Request for Participating OrthoNet Providers

If you are a participating OrthoNet provider, follow the Authorization process outlined in the OrthoNet contract and fax the form directly to OrthoNet at (800) 477-4310. Becoming a participating OrthoNet provider often results in quicker claims processing.

Required Information for Aetna or OrthoNet to ensure they have sufficient information to determine medical necessity.

After the initial MDE, you should submit a copy of your detailed evaluation report to the insurance plan if you are a non-participating provider. If you are a participating provider, submit the evaluation report to OrthoNet. On a regular basis, at least every six months when a new IFSP is developed but recommended quarterly and more frequently if substantial changes are made to the child's IFSP, you should submit updated progress notes.

Affinity Health Plan

Authorization for Out-of-Network Providers

Prior authorization is required for members within all Child Health Plus (CHP) plans.

Providers must send a copy of the initial Multidisciplinary Evaluation (MDE) report, supportive objective clinical data (such as qualified expert commentary/articles), and progress notes if any with the prior authorization form.

After the initial evaluation, you should submit a copy of your detailed evaluation report. On a regular basis – at least every six months/when a new IFSP is issued – but recommended quarterly and more frequently if substantial changes are made to the child's treatment plan, you should submit updated progress notes.

Fax Numbers: (718) 794-7822 or (718) 536-3329

Telephone Number: For questions or assistance with the authorization form, call: (718) 794-7700

Click Here to access the Request for Out-of-Network Authorization Form and enter the following information:

1. The Child's name
2. The Child's date of birth
3. The Child's Affinity ID Number
4. Indicate if: Medicaid, Child Health Plus (CHP) plan, Qualified Health Plan (QHP)
5. Name of child's physician/ primary care provider along with a referral
6. The Therapist's Name and the name of the Agency:
   For example: Jayne J. Smith at Children Are Special
7. Rendering Therapists Individual NPI number
8. Billing Provider Tax ID Number
9. Billing Address – The Provider/Agency Location address if you are an agency provider
10. The Provider/Agency Phone number
11. Fax Number – The Provider/Agency Fax number
12. The Agency's Tax ID number if you are an agency provider, your Tax ID if you are an individual provider

Complete the chart under "Other" with the following information:

1. Date(s) of service(s)
2. Place(s) of service(s)

3. Diagnosis codes—ICD-9/ICD-10 Codes
4. Procedure codes—CPT Codes
5. Number of Hours Requested

Authorization for In-Network Providers

After the initial evaluation, you should submit a copy of your detailed evaluation report. On a regular basis – at least every six months/when a new IFSP is issued – but recommended quarterly and more frequently if substantial changes are made to the child's treatment plan, you should submit updated progress notes.

Affinity Health Plan Website: http://affinityplan.org/

CDPHP (Capital District Physicians' Health Plan)

Physical Therapy and Occupational Therapy is covered without authorization, following contract specific benefit and place of service limits. Speech Therapy requires authorization beyond initial evaluation and is reviewed based on contract specific benefit and place of service limits.

All such services must be provided by participating providers. CDPHP complies with the requirements of law relating to network adequacy, including authorizing medically necessary services by a non-participating provider if no in-network provider is available to provide the requested services.

For services that require authorization, requests may be faxed to (518) 641-3207 (CDPHP Resource Coordination Dept.) or mailed to:

CDPHP
Attn: Resource Coordination
500 Patroon Creek Blvd.
Albany, NY 12206

The following information should be included in the request:

1. Billing Provider Name, Tax ID number, NPI number, Address and Telephone number
2. Rendering Provider Name and NPI number
3. Child's Name, ID number, and date of birth
4. Date(s) of Service(s)
5. Types of services including diagnosis codes (ICD-9/ICD 10 codes) and procedure codes (CPT Codes)
6. Clinical documentation supporting the request

There is no form on the website to complete

Both member and provider will be notified both orally and in writing of the determination.

CDPHP Website: http://www.cdphp.com/

Cigna

OrthoNet

All OT and PT services under the following plans are subject to review by OrthoNet:

- Cigna HMO
- Flexcare/POS
- Open Access
- Open Access Plus products.

OrthoNet serves Cigna plans in the following states: New York, New Jersey, Connecticut, New Hampshire, Maine, Vermont, Massachusetts, Rhode Island, Delaware, Southeastern Pennsylvania, Ohio, and Illinois.

Cigna PPO/EPO and Indemnity policies are not covered under this arrangement for all states except Illinois.

Authorization

Initial therapy visits do not require prior authorization in this program. However, any subsequent visits may be subject to medical necessity review.

OrthoNet will review authorization requests for services that have already been performed (retrospective review) and services that have not yet been performed (prior authorization).

Providers will be notified via fax on the day of the decision with approval status and the number of visits approved.

This document will include your CIGNA authorization number which is needed for claims submission. Once approval has been granted and services rendered, providers should submit their claims.

OrthoNet Telephone Number for Cigna: (866) 874-0727

OrthoNet Fax No. for Cigna: (888) 779-8365

Should providers have questions, need to obtain the status of an authorization, or require approval for additional services because they have not rendered all necessary services, they may call OrthoNet's provider service department at (866) 874-0727.

To obtain prior authorization, complete the OrthoNet fax request form and fax the form to OrthoNet by following the steps below. Links to these forms are on the next page.

Provider Section – Provide the following:

1. Either the facility name or treating provider name with their corresponding identification number
2. When agency providers submit a prior authorization request for services, they should provide the Agency NPI number
3. When offices have multiple locations, list the address and telephone number of the office where the member may be treated
4. Insert fax number to which the decision and authorization number should be sent

Member Information Section – Provide the following:

1. Member name
2. Member date of birth
3. Identification number for member's policy

Request Information Section – Provide the following:

1. Type of service requested
2. Initial Evaluation date
3. Diagnosis Codes

Required Information to Ensure Prompt Decision/Medical Documentation – Current objective clinical data needs to be supplied. Examples of objective clinical data include but are not limited to:

1. Strength
2. Active range of motion
3. Functional status
4. Short- and Long- Term treatment goals
5. Treatment plan

Fax the completed form along with all supporting medical documentation which includes the initial evaluation report and any progress notes and current, objective clinical data that address both the Member's response to therapy and the progress made towards outlined goals to OrthoNet's Medical Management. On a regular basis, at least every six months, you should submit updated progress notes.

Providers may access OrthoNet's Prior Authorization through the following links:

Cigna In-Network Provider Therapy Request Form
Cigna Out-of-Network Provider Therapy Request Form
PT/OT Initial Evaluation Report
PT/OT Initial Evaluation Report for Vestibular Dysfunction
Functional Progress Chart

The first two forms listed above are the required fax forms for coverage under all Cigna policies. The other documents listed above are not required but may be used to provide OrthoNet with medical documentation needed to determine whether prior authorization should be issued for services requested.

Cigna Website: www.cigna.com

EmblemHealth (GHI and HIP)

Authorization

Prior authorization is always *required for members who do not have out-of-network benefits (HMO and Managed Care Plans)*.

Telephone Number for HIP Plans: (866) 447-9717

Fax Number for HIP Plans: (716) 809-8329

Telephone Number for GHI Plans: (877) 244-4466

Fax Number for GHI Plans: (716) 712-2817

The information provided, should contain sufficient clinical and demographic details in order to facilitate prior approval determinations, and will fall under the following categories:

Provider Information

1. Agency's name or individual provider name
2. Billing address
3. Tax Identification Number of the biller
4. Telephone number of the biller
5. Rendering provider NPI number (even if the provider is an agency employee)
6. Billing facility name or provider, including the address, NPI number, and tax ID

Member Information

1. Child's name
2. Child's address
3. Date of Birth
4. Policy and group number

Request Information and Medical Documentation Section

1. Patient's clinical physical data pertinent to the condition proposed for treatment
2. Treatment plan and goals
3. Confirmation of the diagnosis (ICD-9/ICD-10 codes), applicable procedure codes (CPT Codes), and the type of service requested

EmblemHealth website: http://www.emblemhealth.com

Empire BlueCross BlueShield

Empire BlueCross BlueShield does **not** require prior authorization for EI services.

If you have any questions regarding EI claims, please call the number indicated on the remittance. If you receive prior authorization denials for EI services, please call the PCG call center at (866) 315-3747.

Website: https://www.empireblue.com/health-insurance/home/overview

The Empire Plan (New York State Employee Plan)

Telephone Number: (877) 769-7447

Currently, the Empire Plan does not require authorization for EI services unless the service may be considered experimental or investigational. If the child currently receives or may need to receive services under the Empire Plan that may be considered experimental or investigational, or if the provider has any questions regarding the Empire call the number listed above.

Excellus BlueCross BlueShield

Authorization

Prior authorization may be required for OT, PT, ST and behavioral health services for all providers. Because each plan has its own requirements, to ensure you receive the accurate information we recommend you call the phone number on the back of the child's ID card to obtain information. This phone number is for all Excellus Regions and for Participating and Non-Participating Providers.

If an authorization is required, providers should request the authorization over the phone immediately after being assigned. If approved, you will receive the authorization number during the call. *All authorization numbers should be documented in NYEIS and submitted along with all EI claims.*

The information providers will need to give the customer services representative is:

1. Billing Provider name, address, NPI, and Tax ID
2. Referring Provider, NPI and name
3. Child's name, DOB, and member ID #
4. Services: CPT code(s) and Diagnosis code(s)
5. Appointments/Service dates

For providers that participate with Excellus BlueCross BlueShield or participate with other Blues Plans, and know that an authorization is required, they can also request an authorization directly through the Excellus website using the electronic authorization tool *Clear Coverage* that can provide an immediate response. To request the information online:

- Log in to the Excellus website, ExcellusBCBS.com/Provider, with your username and password.
- Click on "Referrals & Auths" menu option, and then click on the "Clear Coverage Auth Tool" link (located under the "Quick Links" menu).
- Log in to "Clear Coverage" with your Facets ID and NPI (National Provider Identifier).

Get complete details, including step-by-step login instructions, by reviewing the Excellus "Clear Coverage Provider Resource Guide" at ExcellusBCBS.com/wps/portal/xl/prv/edu/stafftraining/.

Alternative to Online Authorization Request

Alternatively, providers can access a form on the Excellus website to submit a request to the CS Medical Intake Department through this link: Click Here

Fax No.: Fax the form to (877) 203-9401 and you will receive a fax back from Excellus if approved

To complete the Physical Therapy Form you will need:

1. Child's Name
2. Excellus ID#
3. DOB
4. ICD-9 or ICD-10 Code(s): list the diagnosis code(s)
5. Therapy start date: first date of service for the child
6. Prior PT for this diagnosis: if prior physical therapy services, check yes or no
7. Name of Requesting Physician: list physician that referred the child for services, if none list Early Intervention Services
8. Name of Physical Therapy Provider Tax ID or NPI, Phone#, Fax#: List Individual Therapist Billing Provider Information
9. Request Type: check box Initial Request or Ongoing and indicate number of requested visits
10. For members with unlimited benefits, please complete page two

To complete the Occupational Therapy Form you will need:

1. Child's name
2. Excellus Member ID#
3. Date of Birth
4. Gender
5. ICD Code: list the diagnosis code
6. Prior OT for this diagnosis: if prior occupational therapy services, check yes or no, if yes date
7. Date of onset or exacerbation: first date of service for the child
8. Name of Requesting Physician: list physician that referred the child for services, if none list "Early Intervention Services"
9. Under Occupational Therapist Information:
10. OT Facility: list Individual Therapist Billing Name
11. OT Provider#: list Individual Therapist Billing NPI or Tax ID#
12. OT Phone: list Individual Therapist Billing Provider Phone#
13. OT Fax: list Individual Therapist Billing Provider Fax#
14. Date of Initial Visit: first Date of Service

Additional Online Resources:

- General Early Intervention Services
- General listing of prior authorizations requirements

- Applied Behavior Analysis
- Occupational Therapy
- Auditory Processing Disorder (APD) Testing
- Developmental Evaluation and Testing
- Physical Therapy

Website: https://www.excellusbcbs.com/wps/portal/xl

Healthfirst

Prior authorization is required for OT, PT, and ST for all providers. Prior authorization requests can be obtained by either fax or phone.

Prior Authorization Phone Number: (888) 394-4327

Prior Authorization Fax Number: (646) 313-4603

Authorization via Fax

If you are an Out-of-network provider please follow these steps

Step 1

Print out the Outpatient Authorization Form (located on Healthfirst website under Info for Providers→Provider Resources→Healthfirst Provider Forms→Request for Outpatient Authorization)

1. Go to Website: http://www.healthfirstny.org
2. Click on the Provider Resources tab
3. After dropdown menu appears, click on "Healthfirst Provider Forms"
    a. A list of provider forms will appear
4. Click on "Request for Outpatient Authorization"

Complete all boxes other than those that say "Internal use" and fax the Completed form to the Medical Management department at 1-646-313-4603. A Medical Management representative should contact your organization within 1 business day.

Include the following information on the form:

1. The child's policy number
2. Either the facility's name or treating provider's name with their corresponding Healthfirst provider ID number
3. The Diagnosis codes (include all ICD-9/ICD 10 codes to the EI service(s) being claimed)
4. Procedure codes (include all applicable CPT codes **and** the number of visits you are requesting authorization for the child
5. Contact's name and phone number. (Someone in your practice who is readily available if Healthfirst has questions)
6. The Place of Service – You must **circle** the appropriate one for your particular practice (Options are: DME, Home Health Care, *Outpatient OTT, PTT, ST,* Ambulatory surgery, Subsequent Mental Health, Detox, Chemical Dependency, or Podiatry)

7. The Start and End of care dates--The period of time services should be rendered by your organization to that child

A Medical Management representative will contact your office within 1 business day.

Note: If the circumstances change and additional service visits are needed, you must call Healthfirst at (888) 394-4327 to request approval for additional services, or to submit a new prior authorization request if s needed

Authorization via Phone

Step 1

Gather the same information listed above prior to calling Healthfirst to request authorization for EI services.

Step 2

With form filled out and handy (or at least all the same information as on form) call the Prior authorization number at (888) 394-4327. After the greeting you will be given a list of options. Choose "if you are a provider requesting an authorization."

Step 3

Note the name of the associate who assisted you, date of call, and when you should expect your request to be either approved or denied and who will be contacting you.

Note: If the circumstances change and additional services are needed for the child, you must call Healthfirst at 1-888-394-4327 to request the current authorization be updated, or a new prior authorization approval given.

General Requirements:

Providers must obtain prior authorization from Medical Management for all Healthfirst programs for all out-of-network care. Prior authorization may be requested by the member's PCP or by the specialist who is caring for this member.

The following information must be supplied when requesting prior authorization of services:

1. Member's name and Healthfirst ID number
2. Attending/requesting provider's name and telephone number PCP's name (if not the attending/requesting provider)
3. Diagnosis and ICD-9/ICD-10 Code Procedure(s) and CPT Code(s) and procedure date(s)S

4. Services requested and proposed treatment plan
5. Medical documentation to demonstrate medical necessity

After requesting an authorization, a reference number will be provided to obtain authorization status. Authorization status may be checked at www.healthfirst.org/providerservices.

The authorization should be posted on the website within one (1) business day after it is issued.

If you are an in-network provider, please follow these steps:

Step 1

Download the appropriate form from this website at http://www.orthonet-online.com/dl_HFirstNY.html.

Step 2

Complete the form with the information required above and then submit it by fax along with copies of appropriate medical information to (844) 888-2823.

If you have questions regarding the prior authorization, call Orthonet at (844) 641-5629

Healthfirst Website: http://www.healthfirstny.org/

Orthonet Website: *http://www.orthonet-online.com/dl_HFirstNY.html.*

HealthNow (BlueCross BlueShield of Western New York and BlueShield of Northeastern New York)

Authorization

HealthNow does not require authorization for EI services unless the service may be considered experimental or investigational. If the child is receiving services considered experimental or investigational, call the number listed below.

Prior Authorization Number for HealthNow: (800) 422-7333

Website: https://securews.healthnowny.com

Independent Health

Authorization: Most Independent Health insurance plans do **not** require authorization for common EI services such as occupational therapy, physical therapy or speech therapy services.

To ensure Independent Health does not require authorization for the services you provide, please call the number below.

Telephone Number: (800) 736-5771

MVP

Authorization

MVP will authorize all EI services once EI providers properly submit a Prior Authorization Request form. It is recommended that providers submit the authorization form below as soon as possible after being assigned by BEI to provide services to a child. The MVP case manager will look for the name of the ordering physician, appropriate ICD-9/ICD-10 and CPT codes, along with a report regarding the child's condition including but not limited to an evaluation report.

Once the MVP case manager has identified the child as an EI child, MVP will provide you with a reference number approving all EI services.

If you obtain prior authorization, MVP will NOT deny EI claims:

- Based on medical necessity review
- Because the EI provider is an out-of-network provider even if the plan is an HMO or EPO

Faxing the authorization form to the number below will expedite the process and you will have confirmation you submitted the form if there are questions later

Fax Number: (800) 280-7346

Telephone Number: (800) 568-0458

Mailing Addresses:

MVP Plans – If the child's plan is covered under MVP, as indicated on the child's insurance card, the authorization request form may be mailed to: MVP, 625 State St., Schenectady, NY 12305

MVP Select Care Plans – If the child's plan is administered by MVP Select Care, as indicated on the child's insurance card, the authorization request may be mailed to: PO Box 1434, Schenectady, NY 12305

MVP General Website: https://swp.mvphealthcare.com (Prior Authorization rules are subject to change. If the links below do not work, please consult the general MVP website.)

Authorization Form: To obtain your prior authorization form click here

Instructions

Please include the following information:

1. The Child's full name
2. The Child's date of birth
3. MVP ID Number – insert the ID number on the child's insurance card
4. "Does COB apply?" – If the child has insurance through another plan, check "yes"
    - If the child is also covered under other insurance
        - Provide the plan name(s) and ID number(s) for all other plan(s)
        - Identify the primary plan. If the primary plan does not pay the full cost of the service, list which plan(s) may provide secondary insurance for the child.
5. Requesting physician name – include the name of the referring physician who ordered the initial EI services
    - If an EI provider identifies a need for the child to receive other EI services, the rendering EI provider can refer the child to another provider for additional services. For example, an occupational therapist providing EI services may refer the child to a speech therapist and/or physical therapist if the child could benefit from those additional services.
6. NPI Number – include the referring physician's 10 digit NPI
7. Address – include the address of the referring physician
8. Office contact name: include the referring physician's name or the name of the EI Billing professional(s) who will respond to questions regarding the authorization request
9. Include the referring physician's phone number and fax number
10. The referring physician/referring provider must sign the authorization form and the date of service must be listed
11. Under "Date of Service" – include the child's first date of service
    - Do NOT include an end date
    - Do NOT include a visit limit
    - MVP will stop covering EI services on the child's third birthday

If you are referring a child to another provider or facility, the following additional information will need to be completed:

1. Name of the provider
2. Provider's address, phone number and fax number

3. Check yes if the provider is in the MVP network
4. State the diagnosis, the diagnosis code(s), ICD-9 code(s), and the procedure codes (CPT codes)
5. Specify the services requested and attach all supporting medical documentation including the evaluation
6. Check the applicable boxes identifying where these services may be performed

Oxford

Prior authorization for EI services **is** needed for the Oxford plan, but there are no prior authorization forms to complete and fax.

Oxford Authorization Requirements: If the child is covered under Oxford and requires OT, PT or ST, providers should always request prior authorization by submitting a request through the portal or if necessary by calling the following number**:** 1-800-444-6222

For additional information, please click here

Prior Authorization Requests via Portal: Oxford prefers prior authorization requests be submitted through the Oxford portal at www.oxhp.com/ProviderPortal. Providers should log in to the portal and submit a Patient Precertification Form.

When all information is entered on the form, click **submit.** Oxford will then review the provider's information and contact them if any further information is needed.

Prior Authorization Requests by Mail: In order for the provider to obtain authorization without using the web portal, the provider must mail the Subrogation Notice AND the Evaluation to:

United Healthcare
Attn: Intake Imaging
P.O. Box 29130
Hot Springs, AR 71903

Once the evaluation is received, the review process begins to determine whether authorization will be granted and payment made for requested EI services.

Oxford/United HealthCare Telephone Number: (800) 444-6222

United HealthCare

Currently, United HealthCare (UHC) does not require authorization for EI services unless the service may be considered experimental or investigational. If the child currently receives or may need to receive services under UHC/Oxford that may be considered experimental or investigational, call the number listed above.

Oxford/United HealthCare Telephone Number: (800) 444-6222