Anthem

MediBlue[SM] HMO Medicare Advantage
Prior Authorization Request: Inpatient or Outpatient

Please use this form for prior authorization of medical services. Do not use this form for behavioral health or diagnostic radiology.

1. Member Name:
   First Name: _____ Last Name: _____
2. Certificate Number: _____
3. Date of Birth: Day: _____ Month: _____ Year: _____
4. Requestor Name:
   First Name: _____ Last Name: _____
5. Requestor Address:
   Street 1: _____
   Street 2: _____
   City: _____
   State: _____ Zip: _____
6. Requestor Phone Number:
   Area Code: _____ Phone: _____-_____ Ext.: _____
7. Requestor Fax Number:
   Area Code: _____ Phone: _____-_____
8. Physician/Attending Physician Name:
   First Name: _____ Last Name: _____
9. Physician/Attending Physician Phone Number:
   Area Code: _____ Phone: _____-_____ Ext.: _____
10. Diagnosis Code(s): _____ _____ _____ _____
11. CPT/Procedure Code(s): _____ _____ _____ _____
12. Facility Name (if applicable):_____
13. Admission Date (if applicable): _____
14. Indicate Place of Service:
    ☐ Office ☐ Inpatient ☐ Outpatient

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Additional clinical information and photographs may be required when submitting request.

Please refer to www.anthem.com for listing of current medical policies.

When sending additional clinical information, please print this form and include it with the clinical information required for review:

FAX this form and any additional information to: 877-236-5173

Or Mail to:
Medical Management
MediBlue[SM] HMO Medicare Advantage
15 MetroTech Center, 2nd Floor
Brooklyn, NY 11201