Vermont Medical Prior Authorization Form

Applicable Services:

- **THERAPIES PERFORMED BY OUT-OF-NETWORK PROVIDERS**
- **GENDER AFFIRMING SERVICES**

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, 6) for services that require precertification other than those listed above, or 7) to request a referral to an out of network physician, facility, or other health care provider.

To file via facsimile, send to**: [413-781-1958]**

To file via secure email: Set up login at wellfleet-mail.com and register for secure submittal via Zix. Send requests to: priorauth@wellfleetinsurance.com**.**

For further information or questions, please call the phone number listed on the back of the customer's ID card or call Customer Service team (800)633-7867.

PLEASE NOTE: Determination of medical necessity will be made in an expedited manner upon receipt of this form and all necessary information.
There may be a delay if additional information is needed. Wellfleet may utilize independent review organizations. *Wellfleet utilizes utilization management (UM) vendors for services that require pre-certification, separate from the "Applicable Services" noted at the top of this form. Clinical review criteria and information on how to submit pre-certification requests to UM vendors may be found https://wellfleetstudent.com/forms.

State of Vermont
Uniform Medical Prior Authorization Form

Urgent Request ☐
Non-Urgent Request ☐

Instructions: Please complete all fields and submit all additional treatment information and/or medical notes that support your request for benefits. If you need more room, you may attach additional pages or forms. Send or fax this information to the member's health plan in advance of the proposed services. Please refer to information provided on the health plans' website for submission instructions and contact information.

Patient/Member Information (* Required Field)

*First Name: Middle Initial: *Last Name:

*Health Insurance ID#: *DOB (MM/DD/YYYY): / / *Gender: Male ☐ Female ☐ Unknown ☐

*Address: Apt.#:

*City: *State: *Zip: Telephone #:

Referring/Requesting Provider Information

First Name: Last Name:

NPI/TIN #: Specialty:

Group/Practice Name:

NPI/TIN #:

Address: Suite #:

City: State: Zip:

Rendering/Attending Provider Information

First Name: Last Name:

NPI/TIN #: Specialty:

Group/Practice Name:

NPI/TIN #:

Address: Suite #:

City: State: Zip:

Office Contact/
Person Completing Form:

Telephone #: FAX #:

Required Clinical Information (* Required Field)

*Date of Request: **Is this request for Out-of-Network services?** Yes ☐ No ☐

***Type of Service Requested**

Inpatient Care:
Medical Admit ☐
Mental Health/Substance Abuse Admit ☐
OB ☐
Surgery ☐ Oral Surgery ☐

Outpatient/Office Care:
Acupuncture ☐
Chiropractic ☐
Infusion/Oncology Drugs ☐
Mental Health/Substance Abuse ☐

Therapies:
Occupational Therapy ☐
Physical Therapy ☐
Speech Therapy ☐
Cardiac Rehab ☐

Testing:
Diagnostic Imaging ☐
Diagnostic Medical Test ☐

Other:
DME ☐ SNF ☐ Home Health ☐ Vision/Glasses ☐ Other ☐ - please specify:

*Date Diagnosed:

*Place of Service:
Inpatient ☐ Outpatient ☐ Office ☐ Other ☐ - specify:

*Proposed Date(s) of Service: From: To:

*Facility Where Service Will be Performed:

*Proposed Number of Inpatient Treatment Days:

*Proposed Number of Outpatient Treatment Visits:

*Primary Diagnosis:

*Primary Diagnosis Code:

*Secondary Diagnosis:

*Secondary Diagnosis Code:

*Name of Proposed Procedure or Test:

*CPT/HCPCS or Revenue Code:

*Requested DME:

*DME CPT/HCPCS Code:

*Requested DME Duration (Date(s) of Service):

*DME Purchase Price: $

*DME Monthly Rental Price: $

Additional Clinical Information Attached: ☐ (No. of pages ☐)