

New Mexico Uniform Prior Authorization Form Submission Information

The NM Uniform Prior Authorization Form is available at bcbsnm.com

To Submit the NM Prior Authorization Form for:	Submit to:	Coverage Review:	
BCBSNM Commercial/Retail members for Physical Health services	Electronically: <u>Availity</u> Facsimile: 866-589-8253	M-F 8:00am – 5:00pm MST 800-325-8334 After-hours coverage review: 888-898-0070	
BCBSNM Commercial/Retail members for Behavioral Health services	Electronically: Availity Facsimile: 877-361-7659 / 312-946-3737	24-Hour coverage review: 888-898-0070	
BCBSNM Commercial/Retail members for Pharmacy services	Electronically: <u>CoverMyMeds</u> Facsimile: 877-243-6930	24-Hour coverage review: 800-544-1378	
Blue Cross Community Centennial SM members for Physical Health services	Electronically: <u>Availity</u> Facsimile: 505-816-3854	M-F 8:00am – 5:00pm MST 877-232-5518 After-hours coverage review: 877-232-5518	
Blue Cross Community Centennial SM members for Behavioral Health Services	Electronically: <u>Availity</u> Facsimile: 505-816-4902	M-F 8:00am – 5:00pm MST 877-232-5518 After-hours coverage review: 877-232-5518	
Blue Cross Community Centennial SM members for Pharmacy Services	Electronically: <u>CoverMyMeds</u> Facsimile: 877-243-6930	24-Hour coverage review: 866-689-1523	

Ver. 08/2022

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To file electronically, send to: See Cover S	Sheet		To file via facsimile, send to: See Cover Sheet				
To contact the coverage review team for BCBSNM Commercial/Retail plans, please see the <u>NM Uniform Prior Authorization Cover Sheet</u> on the "Forms" page of bcbsnm.com/provider under the "Education and Reference" tab.							
[1] Priority and Frequency							
		ed [] Provider certifies that applying the standard review usly jeopardize the life or health of the enrollee.					
	c. Frequency Initial [] Extension [] Previous Authorization #:						
[2] Enrollee Information							
a. Enrollee name:	b. Enrollee	e date of birth:	c. Subscriber/Member ID #:				
d. Enrollee street address:							
e. City:	f. State:		g. Zip code:				
[3] Provider Information: Ordering Provider [] Rendering Provider [] Both [] Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.							
a. Provider name: b. Provider type/specialty		cialty:	c. Administrative contact:				
d. NPI #:			e. DEA # if applicable:				
f. Clinic/facility name:		g. Clinic/pharmacy/facility street address:					
h. City, State, Zip code	i. Phone n	umber and ext.:	j. Facsimile/Email:				
[4] Requested medical or behavioral healt	h course of treatme	nt/procedure/devi	ce information (skip to Section 8 if drug requested)				
a. Service description:							
b. Setting/CMS POS Code Outpaties	nt[] Inpatient[]	Home [] Office	[] Other* []				
c. *Please specify if other: [5] HCPCS/CPT/CDT/ICD-10 CODES							
a. Latest ICD-10 Code	b. HCPCS/CPT/CD	T Code	c. Medical Reason				
u. tatest for 10 code	5. Her es/er 1/es	or code	d. Wedical Nedson				
[6] Frequency/Quantity/Repetition Reque	est						
a. Does this service involve multiple treatments? Yes [] No [] If "No," skip to Section 7.							
b. Type of service:			c. Name of therapy/agency:				
d. Units/Volume/Visits requested: e. Frequency/length		th of time needed:					
[7] Description Descri							
a. Diagnosis name and code:							
b. Patient Height (if required): c. Patient Weight (if required):							
d. Route of administration							
*Explain if "Other:"							
e. Administered: Doctor's office [] Dialysis Center [] Home Health/Hospice [] By patient []							

BCBSNM Commercial/Retail plans				
f. Medication Requested	g. Strength (include both loading and maintenance dosage)	h. Dosing Schedule (including length of therapy)	i. Quantity per month or Quantity Limits	
j. Is the patient currently treated with the	e requested medication[s]? Yes* [] No []		
*If "Yes," when was the treatment with	the requested medication started?	Date:		
k. Anticipated medication start date (MI				
General prior authorization request. E medications over alternatives:	explain the clinical reason(s) for the r	equested medications, including an o	explanation for selecting these	
I. Rationale for drug formulary or step-t	herapy exception request:			
 Alternate drug(s) contraindicated or (1) Drug(s) contraindicated or tried; (2 				
 Patient is stable on current drug(s), headverse clinical outcome below. 	nigh risk of significant adverse clinica	l outcome with medication change. S	Specify anticipated significant	
☐ Medical need for different dosage ar	nd/or higher dosage, Specify below:	(1) Dosage(s) tried; (2) explain media	cal reason.	
 Request for formulary exception, Spe effective as requested drug; (2) if there therapy on each drug and outcome 				
□ Other (explain below)				
Required explanation(s):				
neganea explanation(o).				
m. List any other medications patient w	II use in combination with requested	d medication:		
n. List any known drug allergies:				
[8] Previous services/therapy (including	g drug, dose, duration, and reason fo	or discontinuing each previous servi	ce/therapy)	
a.		Date Discontinued	d:	
b.		Date Discontinued	Date Discontinued:	
C.		Date Discontinued	1:	
[9] Attestation		<u>.</u>		
I hereby certify and attest that all informa	ition provided as part of this prior au	thorization request is true and accur	rate.	
Requester Signature		Date		
DO NOT WRITE BELOW THIS LINE. FIELDS				
Authorization #				

Contact's credentials/designation _____