

Prior Authorization Request Form

Submission of this form is only a request for services and does not guarantee approval of the services. Avalon will review the information you provide on this form and the supporting clinical documents that you submit with the form to make a medical necessity determination. Incomplete or missing information will delay our review. Please fax the completed form to Avalon's Medical Management Department at 1-813-751-3760. If you have any questions, please call 1-844-227-5769. Our clinical staff is available Monday thru Friday, 8:00 AM to 8:00 PM Eastern Time.

A prior authorization is not a guarantee of payment. Payment is subject to member eligibility and benefits on the date of service.

Requesting Provider: ☐ Ordering ☐ Rendering

Member's Health Plan: ☐ North Carolina ☐ South Carolina

MEMBER INFORMATION		
First Name:	Last Name:	
ID Card #:	Group #:	
DOB (MM/DD/CCYY):	Health Plan: <input type="checkbox"/> BCBSNC <input type="checkbox"/> BCBSSC	
ORDERING PROVIDER INFORMATION		
First Name:	Last Name:	
NPI:	Phone #:	
Street, Bldg., Suite #:	Fax #:	
City:	Contact Name:	
State:	Zip Code:	Contact Email:
Specialty		
<input type="checkbox"/> AI – Allergy & Immunology	<input type="checkbox"/> ID – Infectious Disease	<input type="checkbox"/> PDO – Pediatric Otolaryngology
<input type="checkbox"/> CD – Cardiovascular Disease	<input type="checkbox"/> IM – Internal Medicine	<input type="checkbox"/> PP – Pediatric Pathology
<input type="checkbox"/> CHP - Child & Adolescent Psych	<input type="checkbox"/> MFM – Maternal Fetal Medicine	<input type="checkbox"/> PPR – Pediatric Rheumatology
<input type="checkbox"/> DBP – Dev Beh Pediatrics	<input type="checkbox"/> MG – Medical Genetics	<input type="checkbox"/> PDS – Pediatric Surgery
<input type="checkbox"/> CGC - Certified Genetic Counselor	<input type="checkbox"/> NPM – Neonatal-Perinatal Med	<input type="checkbox"/> UP – Pediatric Urology
<input type="checkbox"/> CHN - Child Neurology	<input type="checkbox"/> NEP – Nephrology	<input type="checkbox"/> PD – Pediatrics
<input type="checkbox"/> CG - Clinical Genetics	<input type="checkbox"/> NS – Neurological Surgery	<input type="checkbox"/> PS – Plastic/Reconstructive Sur
<input type="checkbox"/> CRS – Colon & Rectal Surgery	<input type="checkbox"/> N – Neurology	<input type="checkbox"/> P – Psychiatry
<input type="checkbox"/> D – Dermatology	<input type="checkbox"/> OBG – Obstetrics & Gynecology	<input type="checkbox"/> PUD – Pulmonary Disease
<input type="checkbox"/> DMP – Dermatopathology	<input type="checkbox"/> ON – Oncology	<input type="checkbox"/> DR – Diagnostic Radiology
<input type="checkbox"/> END – Endo, Diabetes & Met	<input type="checkbox"/> OPH – Ophthalmology	<input type="checkbox"/> REN – Reproductive Endo
<input type="checkbox"/> FP – Family Practice	<input type="checkbox"/> OTO – Otolaryngology	<input type="checkbox"/> RHU – Rheumatology
<input type="checkbox"/> GE - Gastroenterology	<input type="checkbox"/> APM – Pain Medicine	<input type="checkbox"/> SO – Surgical Oncology
<input type="checkbox"/> GP – General Practice	<input type="checkbox"/> PDC – Pediatric cardiology	<input type="checkbox"/> TS – Thoracic surgery
<input type="checkbox"/> GS – General Surgery	<input type="checkbox"/> PDE – Pediatric Endocrinology	<input type="checkbox"/> U – Urology
<input type="checkbox"/> GO – Gynecology Oncology	<input type="checkbox"/> PG – Pediatric Gastroenterology	<input type="checkbox"/> VS – Vascular Surgery
<input type="checkbox"/> HEM – Hematology	<input type="checkbox"/> PHO – Pediatric Hematology-Onc	
<input type="checkbox"/> HO – Hematology & Oncology	<input type="checkbox"/> PN – Pediatric Nephrology	

RENDERING PROVIDER			
Facility Name:			
NPI:		Phone #:	
Street, Bldg., Suite #:		Fax #:	
City:		Contact Name:	
State:	Zip Code:	Contact Email:	
SERVICE DETAILS			
DOS (MM/DD/CCYY):		POS (11, 19, 22, 81):	
Specific Test Requested:			
PROCEDURE CODE INFORMATION			
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
Are any of the codes unlisted codes (81400-81408, 81479, 81599, 84999, 88399, 89240): <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, provide a detailed description of the test(s) for each unlisted code:			
Was genetic counseling completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of counselor:		Credentials:	
Date counseling provided (MM/DD/CCYY):			
DIAGNOSIS CODE INFORMATION			
Primary Diagnosis:		ICD-10 Code:	
Other Diagnosis:		ICD-10 Code:	
Other Diagnosis:		ICD-10 Code:	
Other Diagnosis:		ICD-10 Code:	
SUPPORTING CLINICAL INFORMATION			
Documents submitted: <input type="checkbox"/> Clinic/Office Notes <input type="checkbox"/> Lab Results <input type="checkbox"/> Pathology Report			

Please check the box below if you agree with the following statement:

☐ I attest that I am authorized to request a prior authorization review for the member and the requested services. I further attest that the member's clinical records reflect the information provided on this form.