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: ☐ BCBSNC ☐ BCBSSC	
ORDERING PROVIDER INFORMATION			
First Name:		Last Name:	
NPI:		Phone #:	
Street, Bldg., Suite #:		Fax #:	
City:		Contact Name:	
State:	Zip Code:	Contact Email:	

Specialty		
☐ AI – Allergy & Immunology	☐ ID – Infectious Disease	☐ PDO – Pediatric Otolaryngology
☐ CD – Cardiovascular Disease	☐ IM – Internal Medicine	☐ PP – Pediatric Pathology
☐ CHP - Child & Adolescent Psych	☐ MFM – Maternal Fetal Medicine	☐ PPR – Pediatric Rheumatology
☐ DBP – Dev Beh Pediatrics	☐ MG – Medical Genetics	☐ PDS – Pediatric Surgery
☐ CGC - Certified Genetic Counselor	☐ NPM – Neonatal-Perinatal Med	☐ UP – Pediatric Urology
☐ CHN - Child Neurology	☐ NEP – Nephrology	☐ PD – Pediatrics
☐ CG - Clinical Genetics	☐ NS – Neurological Surgery	☐ PS – Plastic/Reconstructive Sur
☐ CRS – Colon & Rectal Surgery	☐ N – Neurology	☐ P – Psychiatry
☐ D – Dermatology	☐ OBG – Obstetrics & Gynecology	☐ PUD – Pulmonary Disease
☐ DMP – Dermatopathology	☐ ON – Oncology	☐ DR – Diagnostic Radiology
☐ END – Endo, Diabetes & Met	☐ OPH – Ophthalmology	☐ REN – Reproductive Endo
☐ FP – Family Practice	☐ OTO – Otolaryngology	☐ RHU – Rheumatology
☐GE - Gastroenterology	☐ APM – Pain Medicine	☐ SO – Surgical Oncology
☐ GP – General Practice	☐ PDC – Pediatric cardiology	☐ TS – Thoracic surgery
☐ GS – General Surgery	☐ PDE – Pediatric Endocrinology	☐ U – Urology
☐ GO – Gynecology Oncology	☐ PG – Pediatric Gastroenterology	☐ VS – Vascular Surgery
☐ HEM – Hematology	☐ PHO – Pediatric Hematology-Onc	
☐ HO – Hematology & Oncology	☐ 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:
Procedure Code:	# Units:	Procedure Code:	# Units:
Are any of the codes unlisted codes (81400-81408, 81479, 81599, 84999, 88399, 89240): ☐ Yes ☐ No			
If Yes, provide a detailed description of the test(s) for each unlisted code:			
Was genetic counseling completed? ☐ Yes ☐ 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: ☐ Clinic/Office Notes ☐ Lab Results ☐ 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.