nh healthy families

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NEW HAMPSHIRE HEALTHY FAMILIES
INSTRUCTIONS FOR OBTAINING PRE-AUTHORIZATION FOR OPHTHALMOLOGY SERVICES

The following services require pre-authorization by Envolve Vision:

- The following CPT codes, **regardless of where the service is performed**: 15822, 15823, 67900, 67904, 66821, 66982, 66984*, 67908 and J2778 (Lucentis), J0178 (Eylea), J2503 (Macugen) and J3396 (Visudyne).
  *Pre-authorization not required for Ambetter from New Hampshire Healthy Families members
- Any procedure code that is considered an unlisted procedure code as defined by the AMA Current Procedural Terminology (CPT) manual (CPT codes 6xx99)
- Any service that takes place in a non-participating facility or by a non-participating physician
- Experimental and investigational services

Please follow the instructions listed below when requesting a pre-authorization review for blepharoplasty procedures:

- Ensure that the Envolve Vision Medical Pre-Authorization Request Form is **completely** filled out, including office and facility addresses, so your request can be processed in a timely manner.
- Pre-authorization requests for J2778 (Lucentis), J0178 (Eylea), J2503 (Macugen) and J3396 (Visudyne) must be sent using the Pre-Authorization Request for Anti-VEGF Injectables form at https://visionbenefits.envolvehealth.com/forms.aspx.
- Pre-authorization requests must include the codes for all procedures that will be performed during the surgical session.
- The completed form and supporting clinical information including original photos should be sent via secure e-mail to visionumauthorization@envolvehealth.com. If you do not have access to a secure e-mail program, contact the Utilization Management Department at 800-465-6972 and a Care Manager will send you a secure e-mail. Open the secure e-mail attachment, select "Reply to All", and attach the pre-authorization documents for submission to Envolve Vision. If you do not have the ability to transmit records electronically, please mail your request to:
  Envolve Vision, Inc.
  ATTN: Utilization Management Department
  P.O. Box 7548
  Rocky Mount, NC 27804
- After Envolve Vision has received the request it will be entered into the Utilization Management system and a Care Manager will review the information. If necessary, you may be contacted for additional information within 2 business days of receipt.
- **You will be notified within 14 calendar days upon completion of the review.**
  - If the requested service is approved, an authorization letter will be faxed to your office.
  - If the requested service results in a denial, the requesting physician will be offered a peer to peer conference with an Envolve Vision Medical Director.
- Providers must use participating New Hampshire Healthy Families facilities and receive authorization for the facility from New Hampshire Healthy Families. To facilitate this process, Envolve Vision will submit a copy of the authorization to New Hampshire Healthy Families to initiate the facility authorization.
- Participating providers may utilize the Envolve Vision website to verify status of pre-authorization requests at https://visionbenefits.envolvehealth.com/logon.aspx.

Please follow the instructions listed below when requesting a pre-authorization review for services rendered in a non-participating facility or by a non-participating physician:

- Ensure that the Envolve Vision Pre-Authorization Request Form is **completely** filled out, including office and facility addresses, so your request can be processed in a timely manner.
- Pre-authorization requests must include the codes for all procedures that will be performed during the surgical session.
- Fax the completed form and any supporting clinical information to Envolve Vision at (877) 865-1077. Pre-authorization requests for eyelid procedures must include original photos and e-mailed securely or mailed as noted above.
- After Envolve Vision has received the request it will be entered into the Utilization Management system and a Care Manager will review the information. If necessary, you may be contacted for additional information.
- **You will be notified within 14 calendar days upon completion of the review.**
  - If the requested service is approved, an authorization letter will be faxed to your office.
  - If the requested service results in a denial, the requesting physician will be offered a peer to peer conference with a Envolve Vision Medical Director.

Emergency Procedures

Emergent procedures do not require prior authorization. Services provided on an emergent basis in a non-participating facility should be submitted to Envolve Vision for retrospective review and authorization by the next business day after services have been rendered. Emergency care is defined as any health care service provided in a hospital emergency facility (or comparable facility) in order to evaluate and stabilize medical conditions of recent onset and severity (including severe pain), if such condition would lead a prudent layperson (possessing an average knowledge of medicine and health and acting prudently) to believe that failure to get immediate medical care might result in:

- placing the person's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- serious disfigurement
- in the case of a pregnant woman, serious jeopardy to the health of the fetus

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NEW HAMPSHIRE HEALTHY FAMILIES
MEDICAL PRE-AUTHORIZATION REQUEST FORM

☐ **ROUTINE**

☐ **URGENT ***

***A physician with knowledge of the patient's medical condition must determine it a case involving urgent care and that use of non-urgent timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or, based on the physician's opinion, the member would be subjected to severe pain. NOTE: Urgent requests MUST be accompanied by a signed physician's order.**

Date_____ Office Contact_____ Phone_____ Fax_____

Referring/Requesting Physician _____

Treating/Requested Physician _____NPI# _____

TIN #_____License #_____Medicaid #_____ Medicare # _____

Patient Name (Last)_____(First)_____(Middle)_____ DOB _____

ID # _____HMO (Plan) _____ Group # _____

Other Insurer (if any)_____

Date of Admit _____ Date of Service _____ IP/OP (Circle One) Anticipated LOS_____

Facility Name & Address _____

Facility Status: PAR ☐ NON-PAR ☐ Reason for Non-Par Request:_____

Non-Par Facility NPI _____Non-Par Facility Tax ID _____

Diagnosis (must be provided)		**Procedure (must be provided)**		**Circle (appropriate eye(s))**
ICD _____	Description_____	CPT_____	DESCRIPTION _____	RT LT 50
ICD _____	Description_____	CPT_____	DESCRIPTION_____	RT LT 50
ICD _____	Description_____	CPT_____	DESCRIPTION_____	RT LT 50

Medical Reason for Request _____

Attach additional pages if necessary

Patient's Chief Complaint_____

Office Address: _____

PRE CERTIFICATION/AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICE(S) ARE RENDERED.

PLEASE FAX YOUR REQUEST TO: (877) 865-1077 OR MAIL TO:
EVOLVE VISION, INC. ATTN: UTILIZATION MANAGEMENT, PO BOX 7548, ROCKY MOUNT, NC 27804

If denied, please refer to your Provider Manual or call (800) 465-6972 to be informed of your appeal rights.