Authorization Review 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 Preservice Review 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 Standard Time.

An 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: ☐ MVP Health Care
Line of Business: ☐ Commercial ☐ Medicaid

MEMBER INFORMATION	
First Name:	Last Name:
ID Card #	Group #:
DOB (MM/DD/CCYY):	**Member Suffix (two digits)*:**
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent	Member Gender: ☐ Female ☐ Male ☐ Unknown
SERVICE DETAILS	
DOS (MM/DD/CCYY):	POS (11,19, 22, 81):
Have the services been rendered? ☐ Yes ☐ No	Has a claim been filed? ☐ Yes ☐ No
ORDERING PROVIDER INFORMATION	
First Name:	Last Name:
NPI*: **TIN*:**	Phone #:
Street, Bldg., Suite #:	Fax #:
City:	Contact Name:
State: Zip Code:	Contact Email:

Specialty

☐ AI – Allergy & Immunology	☐ ID – Infectious Disease	☐ PN – Pediatric Nephrology
☐ CD – Cardiovascular Disease	☐ IM – Internal Medicine	☐ PDO – Pediatric Otolaryngology
☐ CHP - Child & Adolescent Psych	☐ MFM – Maternal Fetal Medicine	☐ PP – Pediatric Pathology
☐ DBP – Dev Beh Pediatrics	☐ MG – Medical Genetics	☐ PPR – Pediatric Rheumatology
☐ CGC - Certified Genetic Counselor	☐ NPM – Neonatal-Perinatal Med	☐ PDS – Pediatric Surgery
☐ CHN - Child Neurology	☐ NEP – Nephrology	☐ UP – Pediatric Urology
☐ CG - Clinical Genetics	☐ NS – Neurological Surgery	☐ PD – Pediatrics
☐ CRS – Colon & Rectal Surgery	☐ N – Neurology	☐ PS – Plastic/Reconstructive Sur
☐ D – Dermatology	☐ OBG – Obstetrics & Gynecology	☐ P – Psychiatry
☐ DMP – Dermatopathology	☐ ON – Oncology	☐ PUD – Pulmonary Disease
☐ END – Endo, Diabetes & Met	☐ OPH – Ophthalmology	☐ DR – Diagnostic Radiology
☐ FP – Family Practice	☐ OTO – Otolaryngology	☐ REN – Reproductive Endo
☐GE - Gastroenterology	☐ APM – Pain Medicine	☐ RHU – Rheumatology
☐ GP – General Practice	☐ PTH – Pathology	☐ SO – Surgical Oncology
☐ GS – General Surgery	☐ PDC – Pediatric Cardiology	☐ TS – Thoracic surgery
☐ GO – Gynecology Oncology	☐ PDE – Pediatric Endocrinology	☐ U – Urology
☐ HEM – Hematology	☐ PG – Pediatric Gastroenterology	☐ VS – Vascular Surgery
☐ HO – Hematology & Oncology	☐ PHO – Pediatric Hematology-Onc	

RENDERING PROVIDER			
Facility Name:			
NPI*:	**TIN*:**	Phone #:	
Street, Bldg., Suite #:		Fax #:	
City:		Contact Name:	
State:	Zip Code:	Contact Email:	
PROCEDURE CODE INFORMATION (INCLUDE Z-CODE IF KNOWN)** **PROCEDURES SHOULD BE SUBMITTED USING THE SINGULAR DEX ASSIGNED TEST IDENTIFIER** **ORDERING PROVIDERS: CONTACT THE RENDERING PROVIDER TO OBTAIN THE DEX ASSIGNED PROCEDURE CODE FOR THE TEST YOU ARE REQUESTING**			
Procedure Code:		Z-Code:	# Units:
Procedure Code:		Z-Code:	# Units:
Procedure Code:		Z-Code:	# Units:
Procedure Code:		Z-Code:	# Units:
Procedure Code:		Z-Code:	# Units:
Procedure Code:		Z-Code:	# Units:
Procedure Code:		Z-Code:	# Units:
ORDERING PROVIDERS, did you contact the rendering provider for the DEX assigned procedure code? ☐ Yes ☐ No			
If any of the above codes are unlisted codes (81400-81408, 81479, 81599, 84999, 88399, 89240), provide a detailed description of the test(s) for each unlisted code:			
Specific Test Requested:			
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 ☐ Physician's Order			

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

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

*Member Suffix, NPI and TIN are required