Farm Bureau Health Plans Medicare Advantage HMO
Prior Authorization Form

Phone: (800) 608-2667
Fax: (844) 263-1928

Instructions:

1. Please complete the Prior Authorization Form on page 2.
2. Include all clinical information (x-ray reports and diagnostic test results that support the procedure(s) requested).

There are two options for submitting your Prior Authorization Requests to us:

1. Submit your request on-line through the Prior Authorization Portal: www.fbhp.healthtrioconnect.com. PLEASE NOTE this website is specific to MEDICAL prior authorization requests.

2. Fax your Request to: (844) 263- 1928.

3. To provide the information verbally, please call 1-800-608-2667.

Please contact our Prior Authorization Department at 800.608.2667 with any questions or concerns.

Farm Bureau Health Plans Medicare Advantage HMO
Prior Authorization Form
Phone: (800) 608-2667 Fax: (844) 263-1928

PATIENT INFORMATION

Last Name: ______ First Name: ______ DOB: ______
Insured ID #: ______ Phone: ______
Address: ______ City: ______ State: ☐ Zip: ______

PLEASE CHECK ONE OF THE FOLLOWING

☐ **Routine**
☐ **Expedited/ Urgent**: (Applying the standard time-frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function)

REQUESTING PROVIDER INFORMATION:

Provider Name: ______
Group Name: ______
Specialty: ______
Tax ID#: ______
Address: ______
City: ______ State: ______ Zip: ______
Contact Name: ______
Phone: ______ EXT: ______
Fax: ______

PLACE OF SERVICE INFORMATION

Provider/ Facility: ______
Group Name: ______
Specialty: ______
Tax ID#: ______
Address: ______
City: ______ State: ______ Zip: ______
Contact Name: ______
Phone: ______ EXT: ______
Fax: ______

SERVICES

DOS: ______

DME ITEMS (CHECK ONE) ☐ RENTAL ☐ PURCHASE

TYPE OF SERVICE: ☐ OUTPT ☐ INPT ☐ Office ☐ Surgery Center ☐ SNF ☐ Home ☐ Other: ______

Diagnosis Code(s): ______

CPT/HCPCS CODE(S):
(INCLUDE NUMBER OF UNITS PER CODE) ______

PLEASE ATTACH SUPPORTING CLINICAL INFORMATION (E.G., PLAN OF CARE, MEDICAL RECORDS, LAB REPORTS, LETTER OF MEDICAL NECESSITY, PROGRESS NOTES, ETC.)

Other/ Notes:

- ALL SECTIONS OF THIS FORM MUST BE COMPLETED.
- ON ADVERSE DETERMINATIONS, A RECONSIDERATION/EXPEDITED APPEAL MAY BE REQUESTED.

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.