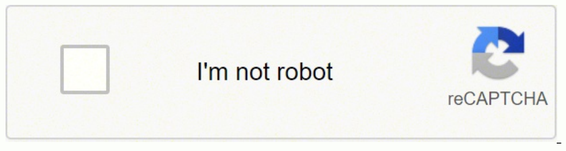


Next

Bcbs of illinois pa forms

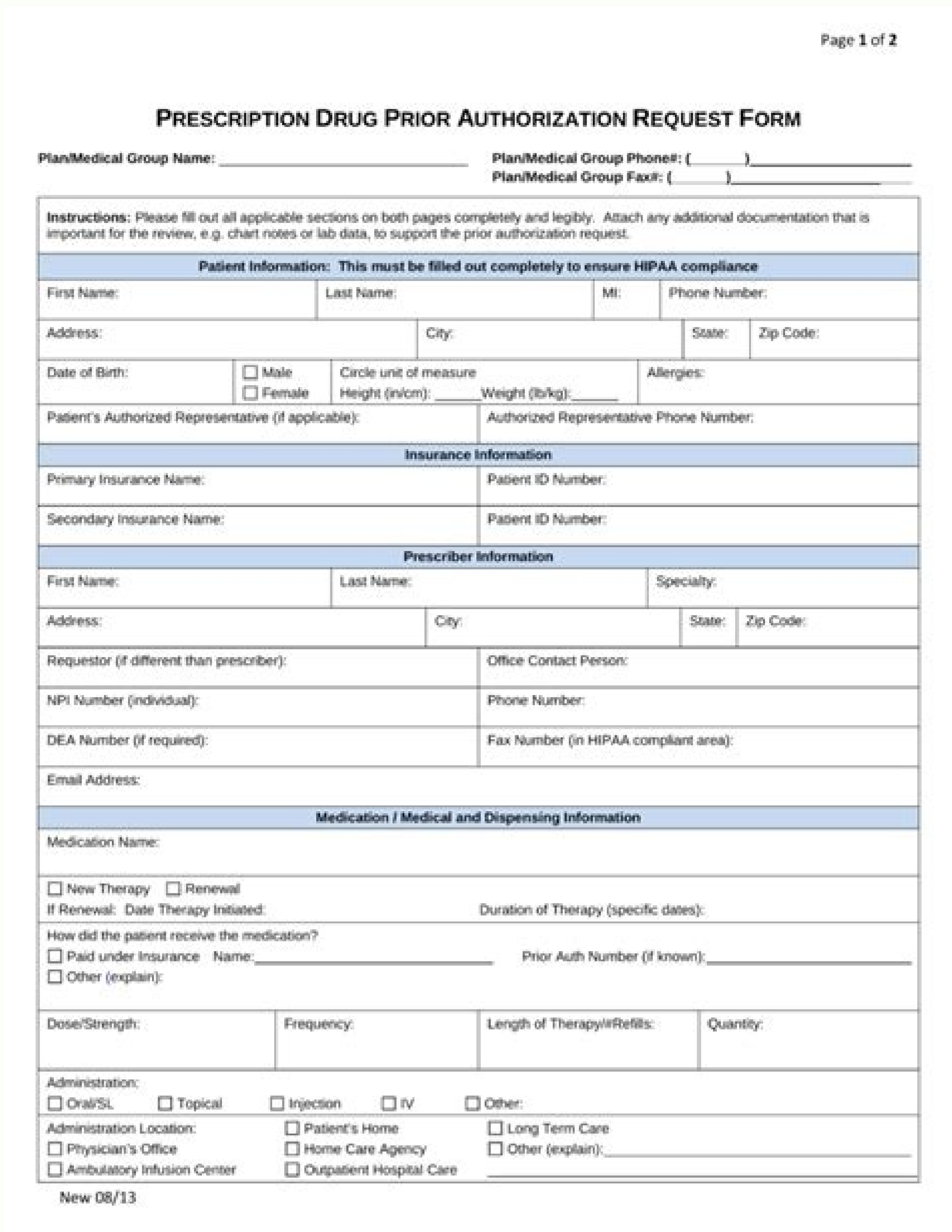
Please note this site's URL has changed to www.highmarkbcbswv.com.

You should be automatically directed to the Highmark West Virginia site within a few seconds.

If you aren't please click here.

The Highmark West Virginia site uses javascript to aid in navigation and display.

We recommend you set your browser to run javascript (also called "scripting" or "active scripting") to be able to use the sites features to their fullest.



Page 1 of 2

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: ____________________ **Plan/Medical Group Phone#:** (______)______________
Plan/Medical Group Fax#: (______)______________

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth: ☐ Male ☐ Female	Circle unit of measure Height (in/cm): ______ Weight (lb/kg):______	Allergies:	
Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:		

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):	Office Contact Person:		
NPI Number (individual):	Phone Number:		
DEA Number (if required):	Fax Number (in HIPAA compliant area):		
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:______________ Prior Auth Number (if known):______________
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location: ☐ Patient's Home ☐ Long Term Care
☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):______________
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care

New 08/13

Prior Authorization Form

Medicare Administrative Prior Authorization for Part B/D Coverage

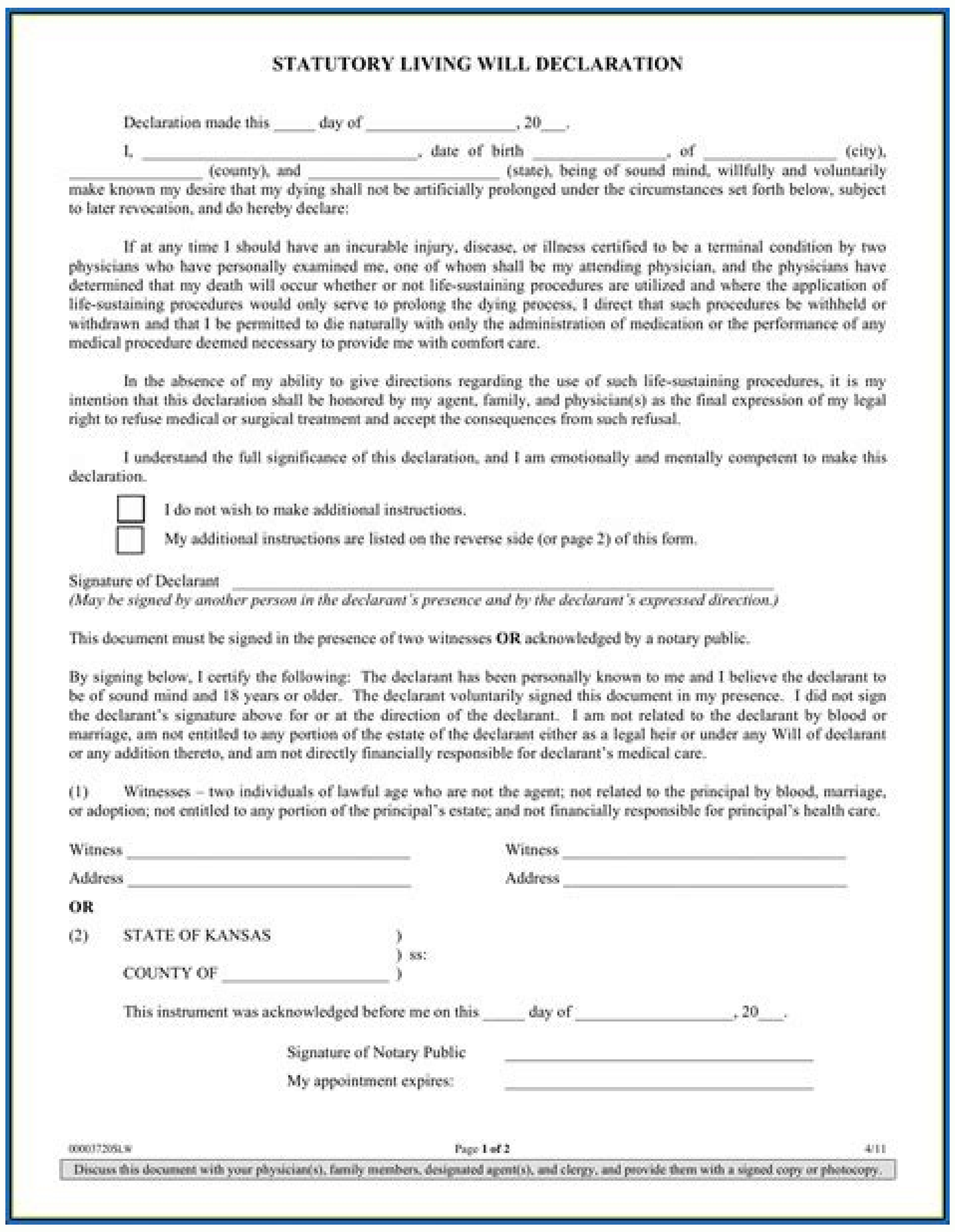
Please provide ALL requested information. Incomplete forms will not be reviewed.

Date: Patient ID#: DOB:
Patient Name: Provider NPI:
Prescribing Physician: Office Contact:
Office Fax #: Office Phone:

☐ HEPATITIS B VACCINE
☐ PARENTERAL NUTRITION (TPN)
☐ ALL OTHER INTRAVENOUS (IV)
☐ ORAL CHEMOTHERAPY AGENTS
☐ NEBULIZED SOLUTIONS
☐ IMMUNOSUPPRESSANTS
☐ ESRD DRUGS

Please add any other supporting medical information that may be useful in the decision-making process:

FAX: (888) 671-5285 or EMAIL:
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.



STATUTORY LIVING WILL DECLARATION

Declaration made this _____ day of ________________, 20___.

I, ____________________________, date of birth ______________, of ______________ (city), ______________ (county), and ____________________ (state), being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, subject to later revocation, and do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would only serve to prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my agent, family, and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full significance of this declaration, and I am emotionally and mentally competent to make this declaration.

☐ I do not wish to make additional instructions.
☐ My additional instructions are listed on the reverse side (or page 2) of this form.

Signature of Declarant ______________________________
(May be signed by another person in the declarant's presence and by the declarant's expressed direction.)

This document must be signed in the presence of two witnesses **OR** acknowledged by a notary public.

By signing below, I certify the following: The declarant has been personally known to me and I believe the declarant to be of sound mind and 18 years or older. The declarant voluntarily signed this document in my presence. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, am not entitled to any portion of the estate of the declarant either as a legal heir or under any Will of declarant or any addition thereto, and am not directly financially responsible for declarant's medical care.

(1) Witnesses – two individuals of lawful age who are not the agent; not related to the principal by blood, marriage, or adoption; not entitled to any portion of the principal's estate; and not financially responsible for principal's health care.

Witness ____________________ Witness ____________________
Address ____________________ Address ____________________

OR

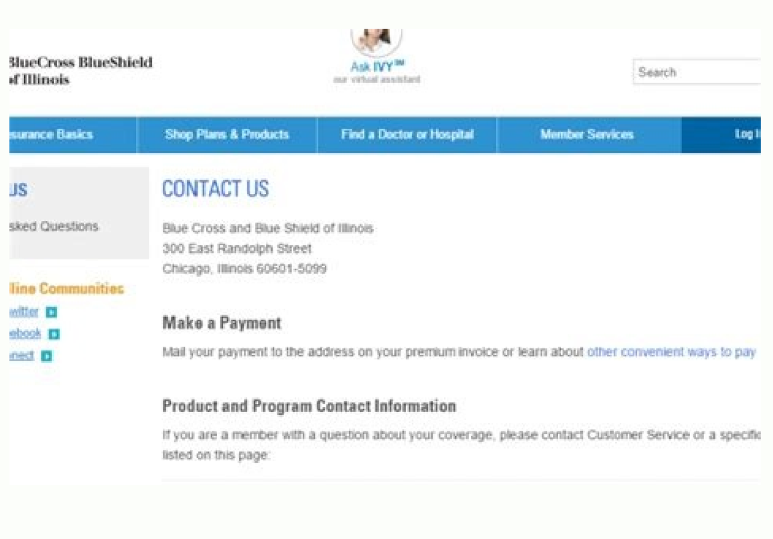
(2) STATE OF KANSAS)
) ss:
COUNTY OF ______________)

This instrument was acknowledged before me on this _____ day of ______________, 20___.

Signature of Notary Public ____________________
My appointment expires: ____________________

00003720SLW Page **1 of 2** 4/11

Discuss this document with your physician(s), family members, designated agent(s), and clergy, and provide them with a signed copy or photocopy.



Bcbs of il pa form. Bcbs of illinois pa form.

Medicines that can be insecure when combined with other medical treatments of medicines that have lower cost, but also effective, medical treatments available and medicines that should only be used for certain health conditionings medical treatments and medicines that are often used or frequently used abuses For cosmetic purposes, the act of surprise was promulgated in 2020 and entered into force on January 1, 2022. It provides federal consumer protections against off-network anticipated accounts called " surprise accounts. Surprise accounts arise in emergencies when Patients usually have little or do not say where they receive care. They also arise in no emergencies when patients in hospitals or networked facilities receive care from providers (such as anesthesiologists) who are not in the network and whom the patient did not choose. The law requires that surprise accounts should be covered without prior authorization and network cost sharing should be applied.1 How do I get a prior authorization? If your healthcare provider is on the network, they will start the prior authorization process. If you do not use a health care provider on the plan network, then you are responsible for obtaining prior authorization. If you do not get it, treatment or medication may not be covered, or you may need to pay more of the pocket. Review your plan documents or call the number on your health plan identification card for more information about treatments, services and supplies that require prior authorization under your specific plan. How does the prior authorization process work? Normally, within 5-10 working days after receipt of the prior authorization request, your insurance company will: approve your request deny your request Ask for more information Recommend that you try an alternative that is less costly but equally effective beforeRequest © These responses are based on the entry of traditional and medical pharmaceuticals © dices in health care company reviewing the requests. If you are unhappy with your own permission response © via, you or your health care provider may request a review of the decision. © saw in emergency situations? N o, prior authorisation © saw no © It would need if you have an emergency and/or need emergency medicine. However, covering the mother costs © Emergency dictions are subject to the terms of your health plan. Why my insurer needs prior authorisation © See? The process of authorising the building © via give your health insurance company the opportunity to review the need for a mother treatment © or medicine in the treatment of your condition. For example, some brand medications are very expensive. During the review, your health insurance company can decide on a genetic alternative © rich or low cost can work so well in treating your condition © Tip. How to authorise the first © Would you help me? The process of authorising the building © via can help you: Reduce the cost of expensive treatments and recipes, first requiring you to try a low cost alternative Avoid combinations of potentially dangerous medicines Avoid prescribed treatments and medicines that you may not need or those that could be addictive CVS. how are you? ® is not available to customers or patients located outside the United States or the United States. We apologize for any inconvenience. For U.S. military personnel permanently seconded or on temporary service abroad, please call our Customer Service team at 1-800-SHOP CVS (1-800-746-7287) if you need assistance with your order. Northland Orthopedics &Sports Medicine in Kansas City, Missouri, offers access to skilled professionals in the treatment of shoulder issues, hips, knee and other aspects of the left-muscle system © Jeez. In 2017, Steven Smith, MD, opened the clanic and was accompanied by Dustin Woyski, DO, with three physicianization assistants ("physicianento"), and a nurse of advanced practice. Together, the team diagnoses and treats ©-esquetic, medical-© problems, of broken bones and tendonitis to joint deterioration. At Northland Orthopedics & Sports Medicine, the team diagnoses sports injuries and other personal injury using

physical examinations, X-rays and a careful analysis of patient symptoms. Some of the conditions that these practitioners diagnose and treat include fractures, sprains, strains, muscle tears, hip pain, shoulder pain, knee pain, sports injury and degeneration and articulate deterioration. Once the team understands the problem, they decide on a non-cirancistic or surgical treatment approach. For example, a doctor may recommend physical rehabilitation or a device. One member of the team can also use other techniques, such as medications, to help the patient manage pain and heal. Sometimes surgery is the best option. For example, the Northland Orthopedics & Sports Medicine team can recommend joint replacement due to arthritis, degeneration or a serious injury. Mark an appointment with Northland Orthopedics & Sports Medicine for Healing and pain relief by calling the office today or requesting an online query. Program your nomination

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