Prior Authorization Request

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 813-751-3760. If you have any questions, please call 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			
Name (first and last):			
ID Card #:		Group #:	
DOB (MM/DD/CCYY):			
ORDERING PROVIDER INFORMATION *Must be accurate and verified prior to submission*			
Name (first and last):		NPI:	
Street, Bldg., Suite #:		City, State, Zip Code:	
Phone #:		Fax #:	
Contact Name:		Contact Email:	
RENDERING PROVIDER			
Name (facility name):		NPI:	
Street, Bldg., Suite #:		City, State, Zip Code:	
Phone #:		Fax #:	
Contact Name:		Contact Email:	
SERVICE DETAILS			
DOS (MM/DD/CCYY):		POS (11, 19, 22, 81):	
PROCEDURE CODE INFORMATION			
Procedure Code:	# Units:	Procedure Code:	# Units:
Procedure Code:	# Units:	Procedure Code:	# Units:
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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:
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Other Diagnosis:	ICD-10 Code:

SUPPORTING CLINICAL INFORMATION
Must be submitted for review
Documents submitted: ☐ *Physician's Lab Order ☐ Medical Record ☐ Lab Results ☐ Pathology Report

*Avalon will not review your PA request without the physician's lab order.

☐ 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.