



Private Fee-for-Service Plan Advanced Determination Of Coverage Request Form

Providers may choose to obtain a written advance coverage determination from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Bravo Health. To obtain an advance coverage determination, call us at 1-888-454-0013 or complete the form online located at www.bravohealth.com and fax it to 1-866-464-0707.

The Plan will render a decision within the guidelines listed below defining timeframes, standard and expedited, provided the Plan is in receipt of all supporting clinical documentation pertaining to the requested service.

Bravo Health will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Bravo Health justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. Expedited decisions are within 72 hours.

In the absence of an advance coverage determination, Bravo Health can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights by contacting Bravo Health Member Services at 1-800-291-0396.



Advanced Determination of Coverage

Please fax to: 1-866-464-0707 or phone: 1-888-454-0013

*** Required Field – please complete all the required fields to avoid processing delay**

*Date: / /

Expedited (defined as **danger to a member’s health if not provided within 72 hours**). Please explain:

Member Information:

*Member Name:

*Member DOB:

*Member ID#:

*Date of Service:

Requesting Provider Information:

*PCP/Requesting Provider:

Contact Person:

*Phone #:

*Fax #:

NPI#:

Referring To (Servicing) Provider Information – If below fields are not answered, Bravo Health will automatically assign Bravo Health’s participating provider network to the member:

Servicing Provider:

Contact Person:

Non-Participating

Phone #:

Fax #:

NPI#:

Facility:

Contact Person:

Non-Participating

Phone #:

Fax #:

NPI#:

If requesting a Non-Participating provider/facility, please explain why:

*Type of Service – please check only one of the boxes below:

ASC

Cosmetic/Reconstructive

DME

Elective Inpatient Admit

Elective Outpatient Surgery

Medication

MRI/MRA/CT PET

Office Procedure

Prosthetics/Orthotics

PT/OT/ST

Transplant Evaluation

Other _____

Clinical Information:

*Diagnosis Code:

Diagnosis:

*Procedure/Service Requested:

CPT Code:

HCPCS Code:

Procedure/Service Description:

Number of visits:

Duration:

Frequency of visits:

Number of previous visits:

*Is supporting Clinical Information Attached?

Yes

No