

Instructions for OIR-B2-2180

1. Priority: Only one of the following options should be marked.
 - a. Standard should be marked if the prior authorization request is not an urgent request or the medical service has not been scheduled.
 - b. Date of Service should be chosen if the requested medical service has been scheduled for a future date. The scheduled date should be written in the corresponding box to the right of the Date of Service label. Note that this is for informational purposes only and that the health insurance issuer is not obligated to provide authorization prior to the scheduled date.
 - c. Urgent should be marked if the patient's life may be seriously jeopardized by applying the standard review time frame.
2. Patient Information: All boxes should be completed.
 - a. Fill in the patient's first name
 - b. Fill in the patient's last name
 - c. Fill in the patient's middle initial.
 - d. Fill in the patient's date of birth beginning with the two-digit numerical representation for the month, followed by the two-digit numerical representation for the day, followed by the four digit year.
 - e. Check the patient's applicable gender.
 - f. Fill in the patient's height in inches.
 - g. Fill in the patient's weight in pounds.
 - h. Fill in the patient's current address if available.
 - i. Fill in city, state, and zip code of the patient's address if available.
 - j. Fill in the patient's phone number if available.
 - k. Fill in the patient's unique health plan identification number.
 - l. If available, fill in the patient's group identification number.
3. Ordering Physician or Clinic Information. In this section, complete all of the applicable boxes for the physician who is requesting the medical service.
 - b. Fill in the provider's unique tax identification number or national provider identification number.
4. Rendering Physician. In this section, complete all of the applicable boxes for the physician who is being requested to perform or administer the medical service. If the ordering physician is the same as the rendering physician, mark the box next to the title. The section will not need to be completed unless any information differs from section 3.
 - b. Fill in the provider's unique tax identification number or national provider identification number.
5. Requested medical Procedure, Course of Treatment, or medical Device information.
 - a. In this box, explain with sufficient accuracy the nature of the requested medical service.

- b. Write the Setting or CMS Place of Service Code. Additionally, mark the box to the right of where the requested medical service will be performed or given.
 - c. If Other was marked in 5.a., write where the requested medical service or device will be given.
6. HCPCS/CPT/CDT CODES. In this section you should explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
- a. Enter the most current International Classification of Disease Code used to classify and code the diagnoses, symptom, or procedure applicable to the patient's condition.
 - b. Explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
 - c. Provide a description of the code used in 6.b.
 - d. Provide a medical reason for requesting the medical service.

Other Clinical Information – If necessary attach other relevant guiding documentation to the request. This does not call for the submission of all documents, just those necessary to make a decision on the request. If this is an out of network request, provide an explanation and attach it to the request.

7. This section should be completed in the event the requested medical service does not fall within the other sections. A description of the nature of the medical service requested and corresponding details should be completed to fully convey what is being requested. Examples of other services may include, but are not limited to, rehabilitation services and home health care services.
8. This section should be completed if prescription medication is being requested.
- a. Fill in the diagnosis name and code of the condition the prescription drug will be used to treat.
 - b. Detail the medication requested.
 - c. Detail the strength of the medication requested.
 - d. Detail the dosing schedule of the medication requested, including the length of therapy.
 - e. Detail the quantity per month or quantity limit of the medication requested.
 - f. Check the appropriate box and explain if necessary.
9. Previous Services or Therapy (Including Drug, Dose, Duration, and Reason for Discontinuing Previous Therapy). This section should be completed if the patient has had previous therapy relating to the medical service being requested. All relevant previous services or therapy should be explained. If there is not enough space, attach another sheet to explain other therapies. If additional guiding documentation is necessary to explain the previous therapy or treatment, that should be attached as well. Include any reason for discontinuing the previous services or therapy.

10. The requesting provider must truthfully certify that all information provided as part of the prior authorization request is true and accurate.