

## New Mexico Uniform Prior Authorization Form Submission Information

To submit the NM Prior Authorization form for:	Submit to:	Coverage Review:
BCBSNM <b>Commercial/Retail</b> members for <b>Physical Health</b> services	Electronically: <b>Availity</b> Fax: 866-589-8253	M-F: 8 a.m. – 5 p.m. MST Phone: 800-325-8334 After-hours coverage review 888-898-0070
BCBSNM <b>Commercial/Retail</b> members for <b>Behavioral Health</b> services	Electronically: <b>Availity</b> Fax: 877-361-7659 or 312-946-3737	<b>24-Hour coverage review Phone:</b> 888-898-0070
BCBSNM <b>Commercial/Retail</b> members for <b>Pharmacy</b> services	Electronically: <b>CoverMyMeds</b> Fax: 877-243-6930	<b>24-Hour coverage review Phone:</b> 800-544-1378
BCBSNM <b>Medicaid</b> members for <b>Physical Health</b> services	Electronically: <b>Availity</b> Fax: 505-816-3854	M-F: 8 a.m. – 5 p.m. MST Phone: 877-232-5518 After-hours coverage review Phone: 877-232-5518
BCBSNM <b>Medicaid</b> members for <b>Behavioral Health</b> services	Electronically: <b>Availity</b> Fax: 505-816-4902	M-F 8 a.m. – 5 p.m. MST Phone: 877-232-5518 After-hours coverage review Phone: 877-232-5518
BCBSNM <b>Medicaid</b> members for <b>Pharmacy</b> Services	Electronically: <b>CoverMyMeds</b> Fax: 877-243-6930	<b>24-Hour coverage review Phone:</b> 866-689-1523

New Mexico Uniform Prior Authorization Form						
To file electronically, send to: See Cover Sheet  To file via facsimile, send to: See Cover Sheet						
To contact the coverage review team for BCBSNM Commercial/Retail plans, please see the NM Uniform Prior Authorization Cover Sheet on						
the "Forms" page of bcbsnm.com/provider under the "Education and Reference" tab.						
[1] Priority and Frequency						
a. Standard [ ] Services scheduled for this	s date:	ited [ ] Provider certifies that applying the standard review iously jeopardize the life or health of the enrollee.				
c. Frequency Initial [ ] Extension [ ] Previous Authorization #:						
[2] Enrollee Information						
a. Enrollee name:	b. Enrollee	e date of birth:	c. Subscriber/Member ID #:			
d. Enrollee street address:						
e. City:	f. State:		g. Zip code:			
[3] Provider Information: Ordering Providence						
<u>Please note</u> : processing delays may occur provider may need to initiate prior author		does not have app	ropriate documentation of medical necessity. Ordering			
a. Provider name:	,		c. Administrative contact:			
d. NPI #:			e. DEA # if applicable:			
f. Clinic/facility name:			g. Clinic/pharmacy/facility street address:			
h. City, State, Zip code	i. Phone n	umber and ext.:	j. Facsimile/Email:			
[4] Requested medical or behavioral heal	th course of treatme	nt/procedure/devi	ice information (skip to Section 8 if drug requested)			
a. Service description:						
b. Setting/CMS POS Code Outpatie	ent[] Inpatient[]	Home [ ] Office	[ ] Other* [ ]			
c. *Please specify if other:						
[5] HCPCS/CPT/CDT/ICD-10 CODES	L HODGE (CDT (CDT C		- Madiad Bassa			
a. Latest ICD-10 Code	b. HCPCS/CPT/CDT Code		c. Medical Reason			
[C] Francisco (Occasión / Decembro)						
[6] Frequency/Quantity/Repetition Requ		o[] If "No " old	in to Section 7			
a. Does this service involve multiple treatments? Yes [ ] No [ ] If "No," skip b. Type of service:		o to Section 7.  c. Name of therapy/agency:				
b. Type of service.			c. Name of therapy, agency.			
d. Units/Volume/Visits requested:		e. Frequency/leng	th of time needed:			
c. rrequency/rengtir of time needed.						
[7] Prescription Drug						
a. Diagnosis name and code:						
b Deticat Height (if required):						
b. Patient Height (if required):  d. Route of administration  Oral/SL[] Topical[] Injection[] IV[] Other*[]						
*Explain if "Other:"						
e. Administered: Doctor's office [ ] Dialysis Center [ ] Home Health/Hospice [ ] By patient [ ]						

BCBSNM Commercial/Retail plans				
f. Medication Requested	g. Strength (include both loading and maintenance dosage)	h. Dosing Schedule (including length of therapy)	i. Quantity per month or Quantity Limits	
j. Is the patient currently treated with the	e requested medication[s]? Yes* [	] No [ ]		
*If "Yes," when was the treatment with	the requested medication started?	Date:		
k. Anticipated medication start date (MI				
General prior authorization request. E medications over alternatives:	explain the clinical reason(s) for the r	equested medications, including an o	explanation for selecting these	
I. Rationale for drug formulary or step-t	herapy exception request:			
<ul> <li>Alternate drug(s) contraindicated or</li> <li>(1) Drug(s) contraindicated or tried; (2</li> </ul>				
<ul> <li>Patient is stable on current drug(s), headverse clinical outcome below.</li> </ul>	nigh risk of significant adverse clinica	l outcome with medication change. S	Specify anticipated significant	
☐ Medical need for different dosage ar	nd/or higher dosage, Specify below:	(1) Dosage(s) tried; (2) explain media	cal reason.	
<ul> <li>Request for formulary exception, Spe effective as requested drug; (2) if there therapy on each drug and outcome</li> </ul>				
□ <b>Other</b> (explain below)				
Required explanation(s):				
neganea explanation(o).				
m. List any other medications patient w	II use in combination with requested	d medication:		
n. List any known drug allergies:				
[8] Previous services/therapy (including	g drug, dose, duration, and reason fo	or discontinuing each previous servi	ce/therapy)	
a.		Date Discontinued	d:	
b.		Date Discontinued	Date Discontinued:	
C.		Date Discontinued	1:	
[9] Attestation		<u>.</u>		
I hereby certify and attest that all informa	ition provided as part of this prior au	thorization request is true and accur	rate.	
Requester Signature		Date		
DO NOT WRITE BELOW THIS LINE. FIELDS		<del></del>		
Authorization #				

Contact's credentials/designation \_\_\_\_\_