Prior Authorization Instructions for Vision Services

envolve Benefit Options

The following services require prior authorization by Envolve Vision:

- Certain surgical and ocular injection services as listed in the applicable health plan provider specifics
- Any service to be rendered by a non-participating physician
- Any service to be rendered at a non-participating facility
- Experimental and investigational services
- Any unlisted procedure code as defined by the AMA Current Procedural Terminology (CPT) manual (CPT codes 6xx99)

Please follow the instructions listed below when requesting a prior authorization:

- All prior authorization requests must be submitted using the Texas Standard Prior Authorization form. The form must include the requesting provider name, NPI, rendering provider name, NPI, Tax Identification Number (TIN), service start and end dates and quantity requested. Facility name, NPI and TIN should be included on the form; Section VI can be used for additional facility information if needed. This information is required to process your request timely.
- Prior authorization requests for Anti-VEGF Injectables must also include the specific Anti-VEGF authorization request form located at https://www.envolvevision.com/providers/provider-forms.html
- Authorization requests must include the codes for all procedures to be performed.
- Providers should use health plan participating facilities and receive facility authorization if required. To facilitate this process, Envolve will submit a copy of your approved authorization to the health plan to initiate facility authorization.
- The completed prior authorization and supporting clinical information can be submitted by fax to 1-877-865-1077 or by secure e-mail to umauthorization@envolvehealth.com.
- Color photos for services such as a blepharoplasty or ptosis repair should be submitted via secure e-mail
- If you do not have access to a secure email program, contact the Utilization Management Department at 1-800-465-6972 and a UM staff member will send you a secure email. Open the secure e-mail attachment, select "Reply All" and attach the authorization documents for submission. If you do not have the ability to transmit records electronically, please mail your request to:

Envolve Vision, Inc.
ATTN: Utilization Management Department
PO Box 7548
Rocky Mount, NC 27804

- After Envolve receives the request, it will be entered into the Utilization Management system for review. If necessary, you may be contacted for additional information.
- You will be notified upon completion of the review.
    - If the requested service(s) is approved, an authorization letter will be faxed to your office.
    - If the requested service(s) is denied, the requesting provider will receive a letter containing appeal rights and be offered a peer-to-peer review with an Envolve Vision Medical Director.

Please follow the instructions listed below when requesting a prior authorization for services rendered by a non-participating provider or facility:

- Ensure the Texas Standard Prior Authorization Request Form is filled out completely as noted above.
- Non-participating providers must include the rendering provider's state Medicaid ID, License number, and a completed W9, located here: https://www.envolvevision.com/providers/provider-forms.html
- Fax: 1-877-865-1077 or email: umauthorization@envolvehealth.com all completed forms and supporting clinical information to Envolve
- After Envolve has reviewed the request for the provider's services, facility requests will be sent to the member's health plan for review.
- The member's health plan will notify you of their decision regarding the non-participating facility.

Emergency Procedures

Emergency procedures do not require prior authorization. Services provided on an emergent basis in a non-participating facility should be submitted to Envolve for retrospective authorization by the next business day after services have been rendered and before a claim is filed. Retroactive review of services may be requested by submitting an authorization request form and medical records to Envolve. Emergency care is defined as any health care service provided in a hospital emergency facility (or comparable facility in order to evaluate and stabilize medical conditions of recent onset and severity (including severe pain), if such a condition would lead a prudent layperson (possessing an average knowledge of medicine and health and acting prudently) to believe that failure to get immediate medical care might result in life, health or ability to regain function may be jeopardized.

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I – Submission:
An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: *Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*
Note: *If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form | Print

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration:_____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____