

Prior Authorization Instructions for Vision Services

The following services require prior authorization by Centene Vision Services (CVS):

- 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:

- Prior authorization requests for Anti-VEGF Injectables must be sent using the specific Anti-VEGF authorization request form located at <https://www.centenevision.com/providers/provider-forms.html>
- For all other requests, ensure that the Centene Vision Services (CVS) Prior Authorization Request Form is filled out completely, including office and facility addresses, provider and facility NPI numbers, provider Medicaid ID, and provider and facility TINs. This information is required to process your request in a timely manner.
- 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, CVS 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 VisionAuthorizations@centene.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:

Centene Vision Services
ATTN: Utilization Management Department
PO Box 7548
Rocky Mount, NC 27804

- After CVS 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 a Centene Vision Services 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 Centene Vision Services (CVS) 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.centenevision.com/providers/provider-forms.html>
- Fax: 1-877-865-1077 or email: VisionAuthorizations@centene.com all completed forms and supporting clinical information to CVS
- After CVS 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 CVS 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 CVS. 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.

Prior Authorization Request Form



VISION SERVICES

ROUTINE

URGENT *

***A physician with knowledge of the patient's medical condition must determine if a case involves urgent/emergent care and that use of routine decision timeframes could subject the patient to severe pain or seriously jeopardize the life, health, or ability of the patient to regain maximum function. NOTE: Urgent requests MUST be accompanied by a physician's signature. The signature may appear either on this form, on the plan of care, or medical record.**

Date _____ Office Contact Name _____ Phone _____ Fax _____

Rendering Physician Name _____ NPI _____

TIN _____ License# _____ Medicaid ID _____ Medicare ID _____

Member Name (Last) _____ (First) _____ (Middle) _____ Member DOB _____

Member ID _____ Health Plan Name _____ Group# _____

Other Insurer (if any) _____

Date of Admission _____ Date of Service _____ IP/OP (Circle One) Anticipated LOS _____

Facility Name & Address _____

Facility Status: PAR NON-PAR Facility NPI _____ Facility TIN _____

Reason for Non-Par Request _____

Diagnosis Code (Required)	Procedure Code (Required)	Check Appropriate Eye(s)		
ICD _____ Description _____	CPT _____ Description _____	RT	LT	50
ICD _____ Description _____	CPT _____ Description _____	RT	LT	50
ICD _____ Description _____	CPT _____ Description _____	RT	LT	50
ICD _____ Description _____	CPT _____ Description _____	RT	LT	50

Medical Reason for Request _____

Attach additional pages if necessary

Member's Chief Complaint _____

Office Address _____

Signature of Rendering Physician _____ Date _____

REQUEST BY FAX: (877) 865-1077 OR SECURE EMAIL VISIONAUTHORIZATIONS@CENTENE.COM
OR MAIL TO: CENTENE VISION SERVICES
ATTN: UTILIZATION MANAGEMENT, PO BOX 7548, ROCKY MOUNT, NC 27804

Authorization is not a guarantee of payment. Covered services are based on member eligibility and benefit limitations at the time service(s) are rendered.

The information contained in this transmission is intended only for the use of the individual or entity to whom it is addressed and may contain information that is confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at Centene Vision Services, PO Box 7548, Rocky Mount, NC 27804, via the United States Postal Service. We apologize for any inconvenience this may have caused you. Thank you.