Allegiance℠
Benefit Plan Management

DIALYSIS PRIOR AUTHORIZATION REQUEST

Please Return <u>this cover sheet</u> and <u>all required information</u> to: Attn: <u>Medical Review</u>

Fax: (406) 523-3111

Phone: (800) 877-1122

Mail: Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

COMPLETED BY ORDERING PHYSICIAN: **Sent By:** _____

Patient Name:	Patient Health Plan ID #:	Patient Date of Birth:
Provider Name:	Provider TIN:	Provider Phone: Provider Fax:
Request Date:	Scheduled Date:	
CPT:	ICD-10 Codes:	

Inpatient ☐ Outpatient ☐

Please provide the following information:

1. Treatment plans.
2. Diagnosis.
3. Estimated length of time for services.
4. Estimated cost for each dialysis treatment and any Epogen required.
5. Medical records supporting request.
6. Letter of Medical Necessity from physician.
7. Records of labs, x-rays or diagnostic studies associated with diagnosis.
8. Any other information deemed necessary to evaluate the pre-authorization request.

Upon receipt of all required information, the Plan will provide a written response to the written request for preauthorization. Please allow 3-5 business days for a response.

The benefits available are conditional on the participant's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. If information obtained at the time of claim places the service(s) in an excluded category or definition, the claim will not be payable. The benefits quoted are not guaranteed. Final determination of benefits to be paid will be made at the time a claim is submitted for payment, with review of the necessary medical records and other information. Predeterminations are valid for 60 days from the issue date.