Quartz Align
Administered by Brighton Health Plan Solutions, LLC

PLEASE ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

Provider Prior Authorization Request Form

Approved prior authorization payment is contingent upon the eligibility of the member at the time of service. Authorizations are not a guarantee of payment, but are based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and/or qualifications and will be determined when the claim is received for processing.

Phone: 866-624-6261
Inpatient fax: 888-862-5118
Outpatient fax: 888-862-6490

☐ **ROUTINE*** ☐ **URGENT*** ☐ **TRANSPLANT***

By checking the URGENT box, the treating physician attests that a routine review time frame may seriously jeopardize the life or health of the member or the members' ability to retain maximum function.

☐ **Check here if this request is related to Transition of Care or Continuity of Care.**

MEMBER INFORMATION

Request Date _____ ID #* _____

Last Name* _____ First Name* _____

Date of Birth* _____ Phone # _____

Street Address _____ City _____ State _____ ZIP _____

☐ **Inpatient*** ☐ **Outpatient***

PLACE OF SERVICE: ☐ Office ☐ Home ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ ASC ☐ SNF
☐ IP Rehab ☐ Infusion Center ☐ Free Standing Radiology Facility ☐ Residential BH Treatment Facility ☐ LTAC

ORDERING/SERVICING PROVIDER INFORMATION:

First Name* _____ Last Name* _____

Tax ID* _____ NPI* _____ Phone #* _____ Fax #* _____

Street Address* _____ City* _____ State* _____ ZIP* _____

FACILITY INFORMATION:

Facility Name* _____

Tax ID* _____ NPI* _____ Phone #* _____ Fax #* _____

Street Address* _____ City* _____ State* _____ ZIP* _____

DX Code (1) _____ DX Code (2) _____ DX Code (3) _____

Additional Information: _____

Date(s) of Service: Start Date(mm/dd/yyyy) _____ **End Date* (mm/dd/yyyy)** _____

CPT/HCPCS			
Qty*	**CPT/HCPCS***	**Description of Service**	**U&C Charge**

Update to Current Auth # _____ # of Visits _____ Requested Extension Date _____

Work/Auto/Other Insurance _____

Our Mailing Address:
Quartz Align
c/o Utilization Management Department
1600 Stewart Avenue, Suite 700
Westbury, NY 11590

*Indicates Required Field