



MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

MyTruAdvantage Prior Authorization/Coverage Determination Form

Email: auth.submit@mytruadvantage.com Fax: 317-860-3624 Phone: 844-425-4280 Online: MyTruAdvantage.com

Section I – General Information					
Review Type: <input type="checkbox"/> Standard <input type="checkbox"/> Expedite (currently inpatient or delay will be detrimental to patient's life or health)			Clinical reason for Expedite:		
<input type="checkbox"/> Initial or Pre-Service Request <input type="checkbox"/> Payment Request <input type="checkbox"/> Advanced Coverage Determination					
Section II – Enrollee Information					
Name		Best Contact Phone:		DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female
Enrollee ID:					
Section III – Provider Information					
Requesting Provider or Facility			Service Provider of Facility		
Name			Name		
NPI#	Tax ID		NPI#	Tax ID	
Phone	Fax		Phone	Fax	
Address			Address		
Section IV – Services Requested (with CPT, CDT, or HCPCS)					
Planned Services or Procedure Code	Inpt/Outpt	Start Date	End Date	Diagnosis Description (ICD Version 10, if available)	Dx Code
Medication ____ (y/n) Provider administered or at facility ____ (y/n) Part of Oncology Treatment					
Inpatient		Outpatient		Observation	
Physical Therapy		Occupational Therapy		Speech Therapy	
Number of sessions:		Duration:		Frequency: Other:	
Home Health -					
Number of visits requested:		Duration:		Frequency: Other:	
DME – MD signed Order Required		Rental \$ ____ Per ____		Purchase \$ ____	
Equipment/supplies (Include any HCPCS Codes):				Duration:	

Is this service being provided outside of the MyTruAdvantage HMO/PPO network? _____ (y/n)

Reason for utilization of out of network provider:

Clinical documentation to support this request is required. Please submit most recent provider office visit notes and other documents related to diagnosis and ordered service. Supporting documentation must be legible and in written/electronic format.

An issuer needing more information may call the requesting provider or authorized representative directly at: _____ or via email at _____.

Preferred method of contact is ☐phone or ☐email

Please note: to ensure the most efficient turnaround time, accuracy of decisions, and prompt notice of decision, please provide all documentation required. This includes all provider contact information including a return notification contact number, as well as the **enrollee or representative's contact information**.

All MyTruAdvantage enrollees are provided a determination call and a notification letter, along with the requesting service provider.

All providers may submit an authorization online by visiting mytruadvantage.com and connecting through the Provider page. Online submissions also allow providers to find up to date authorization status changes and determinations.

If you have questions regarding which services require Prior Authorization, which Part B drugs require pre-service review for medical necessity, or seek certain policy information, please visit mytruadvantage.com or contact us by phone at 844-425-4280.

MyTruAdvantage reserves the right to “downgrade” or “extend” authorization request decision time frames from Expedited to Standard status upon review if the plan determines that the standard turnaround time (72 hours to 14 days for prior authorization) will not cause detriment or delay to an enrollee’s life or health. Upon any changes in status, MyTruAdvantage will issue a notification to the requesting party in form of phone call and letter indicating the change. The enrollee and provider have the right to issue an expedited grievance, should they disagree with the plan’s determination to extend the timeframe. Information for issuing a grievance are included on the letter.

Authorizations are accepted by fax, email, and online submission 24 hours per day 365 days per year, and by phone Monday through Friday 8am – 5pm EST except for government-issued holidays. Voicemails containing authorization requests are not guaranteed to be received during non-business hours. Those who wish to initiate an authorization should fax or email their request to 317-860-3624 or auth.submit@mytruadvantage.com; or submit the request and supporting documentation through the online portal at mytruadvantage.com.

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal. MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.844.425.4280 (TTY: 711) Y0150_MM0068_C