Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.
Independence Blue Cross (Independence) has transitioned to a new medical management system for processing requests for authorization. As a result, the Authorizations transaction on the NaviNet® web portal has been updated. The new transaction streamlines the various authorization submission types into one workflow.

Note: Internet Explorer and Google Chrome are the optimal browsers for this transaction.

The available authorization types include:
- Ambulance (Land) (non-emergency ambulance transportation)
- Chemotherapy
- Durable medical equipment (DME) – purchase and rental
- ER admission
- Home health
- Home infusion
- Infusion therapy
- Medical surgical
- Skilled nursing facility (SNF) (requests for placement in a SNF)

Please note:
- At this time, SNF authorization requests may only be submitted through the portal by SNFs. In the short term, facilities can continue to call Independence Clinical Services at 1-800-ASK-BLUE with these admission requests.
- Ambulance authorization requests may only be submitted by ambulance service providers.
- Providers will continue to submit authorization requests to AIM Specialty Health® (AIM) and CareCore National, LLC d/b/a eviCore healthcare (eviCore), independent companies, through the current AIM and eviCore transactions.

Authorization requests
To initiate a new prior authorization request, use the following steps.

Select Authorizations from the Workflows menu, and then select Authorization from the fly-out menu.
From the Authorizations screen, select the **Create New Authorization** link:

From the Patient Search screen, enter:

a. The member identification number as displayed on the member's card. OR
b. The member’s last name, first name, and date of birth (DOB). AND
c. You will also need to enter the anticipated service date for the service.
d. When complete, select **Search**.

**Note:** You **cannot** submit authorization requests through the new Authorization transaction for out-of-area members, including Federal Employee Program (FEP).
Note: The below guide provides you with allowable date ranges for each authorization service type. For example, non-emergency Ambulance Land authorization requests can be submitted up to 30 days in advance of the current date, or retroactively up to 2 days prior to the current date.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Future Date Maximum</th>
<th>Retroactive Date Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Land</td>
<td>30 days after current date</td>
<td>2 days prior to current date</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>183 days after current date</td>
<td>2 days prior to current date</td>
</tr>
<tr>
<td>DME Purchase/Rental</td>
<td>183 days after current date</td>
<td>2 days prior to current date</td>
</tr>
<tr>
<td>ER Admission</td>
<td>current date</td>
<td>365 days prior to current date</td>
</tr>
<tr>
<td>Home Health</td>
<td>30 days after current date</td>
<td>2 days prior to current date</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>183 days after current date</td>
<td>2 days prior to current date</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>183 days after current date</td>
<td>2 days prior to current date</td>
</tr>
<tr>
<td>Medical Surgical</td>
<td>183 days after current date</td>
<td>2 days prior to current date</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>30 days after current date</td>
<td>2 days prior to current date</td>
</tr>
</tbody>
</table>

If the Patient Search screen returns multiple members, a Search Results screen will present you with the list of members meeting your search criteria. You will need to select the appropriate member by clicking on the row before proceeding to the Create New Medical Authorization screen.

Note: If the Patient Search screen returns multiple products for an individual member, an on-screen warning message is displayed:

“It appears that the Member you have selected has multiple active coverages. If you are not clear which coverage to select, please call Customer Service at 1-800-275-2583.”

If the Patient Search screen returns a single member with a single active plan, you will immediately proceed to the Create New Authorization screen.
To begin the submission process, you will need to first select a Service Type.

### Service type

Click inside this field and select the authorization type from the list of provided options, or use the type-ahead feature and enter the first few letters of the service type.

The following service types will appear:

- Ambulance (Land) (New: for non-emergency ambulance transportation)
- Chemotherapy
- Durable Medical Equipment Purchase
- Durable Medical Equipment Rental
- ER Admission
- Home Health
- Home Infusion
- Infusion Therapy
- Medical Surgical
- Skilled Nursing Facility (New: for placement in a SNF)

**Note:** Not all providers can submit requests for all of the above service types. For example, only hospitals can submit ER Notification requests.
As stated earlier in this guide, at this time SNF authorization requests may only be submitted through the portal by SNFs. In the short term, facilities can continue to call Independence Clinical Services at 1-800-ASK-BLUE with these admission requests.

Ambulance authorization requests may only be submitted through the portal by Ambulance Service Providers.

If you are not permitted to submit a request, you will receive a response similar to the below:

“Your permissions do not allow you to submit an Authorization associated with the selected Service Type.”

If you attempt to submit an authorization requests for services supported by AIM or eviCore, and you do not utilize the current AIM and eviCore transactions, you will receive one of the below responses:

“The service you have requested is managed by AIM. Please click on the link below to access AIM.”

“The service you have requested is managed by eviCore. Please click on the link below to access eviCore.”

You will also have the option to discard the authorization.

Note: If you need to go back and modify the service type further along in the workflow and prior to selecting Submit, you will receive the below on-screen message indicating all authorization selections will be cleared. You would then need to complete the request form again.
Place of Service
Click inside this field and select the place of service from the list of provided options, or use the type-ahead feature and enter the first few letters of the place of service.

Note: Some authorization service types will limit the selection of Place of Service options. For example, when selecting Infusion Therapy as a service type, Office and Outpatient are the only Place of Service options available for selection. Additionally, some service types automatically default to a place of service, and you will not be required to make a selection. Home Health and SNF are two service type examples that do not require you to enter a place of service, so the field will not display on the screen.

Also, the selection of some service types may change the field label display of the date and provider fields. For example, when selecting SNF, the field label changes to Date of Admission and the provider field label changes from Ordering Provider to Admitting Provider.

Date of Service or Date of Admission
When applicable, the Date of Service or Admission Date defaults to the date you entered on the Patient Search screen. If you need to update this date, use the Wayfinder to return to the Patient Search Screen and update the date before continuing.

Ordering/Admitting Physician
The previously selected authorization service type will influence how you complete this field. Some service types will require you to select from the provided drop-down menu. Other service types will allow you to select from the provided drop-down menu or to manually enter the physician information.

Note: We recommend using the type-ahead feature and entering the physician’s last name, individual NPI number, or group NPI number to help narrow down the search results. Please keep in mind that a physician can be associated to multiple unique provider groups. Select the provider/group combination record that best applies.
Some service types will allow you to first search for the ordering/admitting provider by clicking inside the field and entering a minimum of three characters of the physician’s name, address, NPI, Tax ID, or Payer ID. If the provider is not found, you can then manually enter the physician’s information by selecting the *Manually Enter Provider* link.

**Manually Enter Provider**

Complete the fields as indicated, including:

a. Group/Facility Name
b. Clinician Name
c. Address
d. Phone Number

**Note:** if the Ordering/Admitting physician does not participate with the member’s product, you may receive the following red-line message:

Although the selected Ordering/Admitting Physician is participating with the Health Plan, they are not contracted for the Member’s specific network. If the requested Service Type is Ambulance Land, DME, ER Admission, Home Health, Home Infusion, or Skilled Nursing Facility, please use the Manually Enter Provider link to enter your provider information.

If the requested service type is Chemotherapy, Infusion Therapy, or Medical/Surgical, please do not use the Manually Enter Provider link if offered. Instead, refer to the Network Facility/Provider Inquiry transaction to locate a participating Provider.

Please follow the instructions as indicated. If you require further assistance, please contact the eBusiness Hotline at 215-640-7410.
Servicing Provider/Servicing Facility
The previously selected authorization service type and your organization’s role as it relates to the request will influence how you complete this field.

Begin by clicking inside the field to access the search criteria.

- If you are the servicing provider or facility and the place of service is \textit{inpatient} or \textit{outpatient}, you can only search for your group or facility.
- If you are the servicing provider or facility and the place of service is \textit{office}, you are required to search for your practice or facility. This information is not automatically populated.
- If the requested services are to be provided by another provider or facility, you can search for any provider or facility participating in the member’s network.

The following search options are available:

- **Specialty:** Click within this field to select from a list of specialties.
  - If you do not see a specific specialty listed, use the type-ahead feature and enter the first few characters of the specialty name to locate.
  - The Specialty field is not required. You can search for a Group/Facility without using the Specialty field.
- **Group/Facility Name:** Enter a professional group name or facility name. This field has the type-ahead feature.
  - Our provider data repository includes Home Health agencies with a group name of “VNA” versus “Visiting Nurse Association”. Please be aware of this naming convention when searching for Servicing Provider/Facilities using Group/Facility Name.
- **Group NPI:** Enter the professional group NPI or facility NPI.
- **Last Name:** Enter the individual practitioner’s last name.
- **First Name:** Enter the individual practitioner’s first name.
- **Location:** Enter a city, state, or ZIP code.
If you have mistyped information when searching, you can try again by selecting *Change Search Criteria*.

If a list of Servicing Providers is returned, multiple pieces of data are returned for each provider:

- Benefit Tier
- Provider (NPI)
- Group/Facility (NPI)
- Address
- Tax ID
- Provider ID
- Program

Please review the options carefully when selecting the servicing facility from the returned list. Key provider details such as NPI, address, and specialty are available to assist with selecting the appropriate record.
**Diagnoses**

Click inside this field and enter three or more characters of the diagnosis code or diagnosis description. *Note:* When entering more than three characters of the diagnosis code, be sure to *include* the decimal.

A list of qualifying diagnoses will display. Make your selection by clicking on the applicable row. You can enter up to ten diagnoses.

*Note:* The first diagnosis is always designated as primary. Please ensure the key diagnosis is designated as primary before submitting your request. If it is not, re-order as needed.

![Diagnoses Table]

To remove or re-order a diagnosis, place your cursor over the designated row to view edit options.

![Diagnoses Table with Edit Options]

Selecting the arrow icon allows you to move the diagnosis upward or downward in the order. To designate a different diagnosis as primary, select the 👆 icon on that diagnosis line. The trashcan (🗑️) icon permits you to remove the diagnosis all together.

**Services and Durable Medical Equipment**

*Note:* When entering an ER Admission request, please skip this section of the submission form. Procedure codes are not required for ER Admissions.

This section has three fields to complete:
1. Enter the Service From/To date (mm/dd/yyyy) or make your selection using the pop-up calendar. The Service To date may be optional in some instances (e.g., DME purchase).
2. Enter the Procedure Code. *Note:* The primary procedure should always be entered first.
3. Enter the number of Units and select the appropriate qualifier – Days or Visits – from the provided drop-down menu. The below table can be used as a reference when completing this field.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Sub-Type</th>
<th>Place of Service</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>N/A</td>
<td>Inpatient</td>
<td>Days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office</td>
<td>Visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient</td>
<td>Visits</td>
</tr>
<tr>
<td>Medical Surgical</td>
<td>N/A</td>
<td>Inpatient</td>
<td>Days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office</td>
<td>Visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient</td>
<td>Visits</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>N/A</td>
<td>Office</td>
<td>Visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient</td>
<td>Visits</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
<td>N/A</td>
<td>Units</td>
</tr>
<tr>
<td>Purchase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
<td>N/A</td>
<td>Units</td>
</tr>
<tr>
<td>Rental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Infusion</td>
<td>N/A</td>
<td>N/A</td>
<td>Units</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
<td>Visits</td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td>N/A</td>
<td></td>
<td>Visits</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>N/A</td>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Home Uterine Monitor</td>
<td>N/A</td>
<td></td>
<td>Units</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>N/A</td>
<td></td>
<td>Visits</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>N/A</td>
<td></td>
<td>Visits</td>
</tr>
<tr>
<td>Prenatal Nursing</td>
<td>N/A</td>
<td></td>
<td>Visits</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>N/A</td>
<td></td>
<td>Visits</td>
</tr>
<tr>
<td>Social Work</td>
<td>N/A</td>
<td></td>
<td>Visits</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>N/A</td>
<td></td>
<td>Visits</td>
</tr>
<tr>
<td>ER Admission</td>
<td>N/A</td>
<td>N/A</td>
<td>Days</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>N/A</td>
<td>N/A</td>
<td>Days</td>
</tr>
<tr>
<td>Ambulance (Land)</td>
<td>N/A</td>
<td>N/A</td>
<td>Units</td>
</tr>
</tbody>
</table>

*Note:* SNF authorizations will not require a procedure code, and the units will default to one day. Medical Surgical authorizations with a place of service of Inpatient will default to one unit. Medical Surgical authorizations with place of service of either Office or Outpatient will allow the entered unit quantity.
Once the above fields have been completed, select Add New Service Line. The service should then display in the lower portion of this section as illustrated below.

Repeat the above steps to add any additional services that are applicable.

Note: The first procedure code will be designated as primary. Please ensure the key requested procedure is designated as primary before submitting your request. If it is not, re-order as needed.

To remove or re-order a procedure code, place your cursor over the designated row to view edit options.

Selecting the arrow icon allows you to move the procedure code upward in the order. To designate a different procedure as primary, select the icon on that procedure line. The trashcan icon permits you to remove the procedure all together.
Notes
This optional section allows you to enter additional comments relating to your authorization request. The maximum number of characters is 499.

Contact Information
This section is where you will enter your contact information should we need to contact you for additional information about the request. While we encourage you to complete all fields within this section, only Contact Name and the Phone Number are required.

If you would like to save your contact information for future submissions, please check the box as indicated.

Once you have completed all the required fields, select Submit and your authorization request will be forwarded to the health plan.

Sample Error Messages
After an authorization is submitted, you may receive red-line messages if there are issues related to the information entered. For example, you may receive the following message if the service/procedure does not require preauthorization:

“The Primary Procedure Code does not require preauthorization. Please check the member’s benefits as typically this service is not a Covered Service under the health benefit plan.”

Or, you may receive a message advising that an incorrect value was entered/selected, for example:

“An invalid unit type was selected. Valid unit types are Visits.”

Note: If you keyed an incorrect service type, you will need to remove the entire service line and re-enter with the correct type.
Surveys
Depending on the type of authorization request you initiate through the portal, you may be prompted to complete a survey. Your response to survey questions help expedite the processing of your request. Some of the more common services that may trigger a survey include:

- Ambulance (Land) non-emergency transport
- Home Health
- Durable Medical Equipment – purchase and rental
- Skilled Nursing Facility admission requests
- Home Infusion
- Infusion Therapy

*Note:* Not all surveys will be available with the initial release of the new Authorizations transaction. In those instances, your request will pend and someone from the Independence Care Management team will contact you directly should additional information relating to your request be required.

The survey Save feature allows you to save an incomplete survey. You can then go to the Authorization Log to retrieve the incomplete request and finish. After entering responses to all survey questions, select Submit.
The below screen will be returned advising you that the survey was accepted. Select Next to be returned to a summary of your submitted authorization:

**Note:** The final submission confirmation screen does not provide a detailed status for each requested service line. You will need to refer to the Authorization Inquiry Details screen to monitor the status for individual service lines.
The returned ribbon at the top of the screen shows the status of the submitted authorization, the authorization number, and the effective date of the submitted authorization.

There are additional links returned along with the status of the submitted authorization:

- **Create New.** This allows the ability for the user to initiate another new authorization for the same patient. By utilizing this link, a window will be returned showing the member’s information and a prompt to enter a new Date of Service.
  Enter a Date of Service for the new authorization.

*Note:* You can also create an authorization for a different patient from the Create New Authorization pop-up by selecting *Go to Patient Search* and searching for a different patient.
When a Date of Service is entered and the user selects *Create*, the returned screen contains all of the member’s data and allows the user to begin entering the data for the new authorization.

- **Authorization Search.** This takes the user to the Authorization Inquiry search screen (refer to the Authorization Inquiry section of this guide).
• **View/Print as PDF.** This allows the user to view and print a PDF version of the submitted authorization. Below is an example of a printer-friendly PDF version of an authorization.

![Electronic Authorization](image)

**Duplicate Authorization Requests**

If the submitted authorization request is determined to be a duplicate of a previous request, a status of Duplicate will be returned along with the previous authorization number.

![Duplicate](image)
Authorization Inquiry

The new Independence Authorizations workflow allows you to search for all authorizations associated with your organization as a requesting or servicing provider. This will also be the means for which you will obtain your Authorization Census Report.

Please note:

• At this time you cannot limit your search to only Requesting or Servicing Provider for authorizations created on the new authorization transaction. The transaction currently returns all authorization requests associated with your organization regardless of whether your organization is the requesting or servicing provider.

• You may check the status of finalized authorizations submitted through AIM and eviCore. Please note, the below dates may be subject to change.
  – To check the status for eviCore pended authorizations, please use the eviCore option under the Authorizations transaction for all commercial and Medicare Advantage HMO and PPO members. For more information, call eviCore Support at 1-866-686-2649.
  – To check the status for AIM pended authorizations please use the AIM option under authorizations. For more information call AIM Support at 1-800-275-2583 and follow the prompts to AIM.
  – To check the status of AIM or eviCore authorizations that were finalized before September 18, 2017, you must include the member ID or authorization number in your search criteria.
  – To check the status of AIM or eviCore authorizations that were finalized on or after September 18, 2017, you are not required to enter the member ID or authorization number in your search criteria.

• Authorization inquiry allows you to view newly submitted authorization requests sourced from our legacy system. Authorizations sourced from our legacy system will be available for inquiry until December 31, 2017.
  – When searching for requests submitted prior to the release of the new transaction, you must include the member’s ID number or authorization number in the search criteria.
  – If searching for an authorization submitted through the legacy process, you will need to select the Requesting or Servicing provider radio button.

• You will be able to identify legacy authorizations from Open authorizations by the absence of EXT for CAS authorization number on the Inquiry Search Results screen.

• The Authorization Details screen provides service line status detail for each requested service. Use this screen to monitor the status for individual services.

• When performing an authorization search using only date range as the search criteria, your search results may include authorizations for members covered under FEP. While you can view the authorization detail, you cannot amend or create a new request for FEP members through the NaviNet.
To perform an Authorization Inquiry, select *Authorizations* from the Workflows menu, and then select *Authorization* from the fly-out menu.

You are then presented with the Authorizations screen. The following fields are required to be completed:

- Requesting or Servicing Provider name (this field has the type-ahead feature) or select from the drop-down list.
- Date Range of the authorization(s) for which you are searching. This field defaults to the most current 30-day period.
Click inside the Servicing Provider field and select your organization. The drop-down menu display includes the group/facility name and NPI, address, tax ID, and internal provider number (payer ID) to assist with your selection.

The Date Range field defaults to the most current 30-day period. To modify the date, click inside the field. You have the option to select a pre-defined date range (e.g., last seven days) or to define a custom range using the calendar tool. If using the calendar tool, you will need to select a begin date using the calendar on the left. To select an end date, use the calendar on the right.
In the Optional Details section, there are additional fields that can be used to further narrow the number of authorizations returned. Data may be keyed in either Member ID or Authorization Number or both fields. If the Optional Details fields are left blank, then all authorization requests for the identified provider are returned regardless if your organization is the requesting or servicing provider.

Select Search to view the list of authorizations meeting your search criteria.

*Tip:* If your search returns multiple authorizations, you may use the Filter Results text box to narrow the results. If more than 500 records return in the result set, you will be prompted to narrow your search criteria.

The search results may contain authorizations for patients covered under Independence or its affiliates; therefore, you will not see a plan logo on any of the Search, Detail, or View PDF screens.
Below is a sample report display.

The report display includes:
- authorization number
- patient name and ID
- authorization status
- requesting provider name
- servicing provider name
- procedure (when applicable)
- date of service

**Note:** There is no print feature offered on this screen. If you want to save a copy of the report, you will need to manually capture the screen and copy/paste to an external document. For large reports, you may want to perform searches using a smaller date range so fewer records are returned and the information is more easily captured.

**Authorization numbers**

The structure of the authorization number may vary depending upon how and where the original authorization request is submitted. For example, if the original request is submitted through NaviNet, the authorization number will display with a prefix of EXT. However, if the original request is submitted via phone, the authorization number will display a prefix of CASE.

<table>
<thead>
<tr>
<th>Origin of authorization</th>
<th>Sample authorization number</th>
</tr>
</thead>
<tbody>
<tr>
<td>NaviNet</td>
<td>EXT - 12345</td>
</tr>
<tr>
<td>Telephone</td>
<td>Case - 7890</td>
</tr>
<tr>
<td>AIM authorization</td>
<td>A#12345</td>
</tr>
<tr>
<td>eviCore authorization</td>
<td>#76543</td>
</tr>
</tbody>
</table>
To view additional authorization detail for a particular request, select the desired record.

The selected authorization is returned:

**Note:** The authorization detail screen limits the display of diagnoses codes to three. If more than three diagnoses were submitted with the original request, that information is retained within our internal medical management system.

If you wish to return to the authorization list, select *Back to Medical Authorizations Search Results* in the upper left section of the screen:
Authorization Status

Within Authorization Inquiry, authorizations may display various types of status:

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved</td>
<td>Authorization request has been submitted to the health plan and approved.</td>
</tr>
<tr>
<td>Cancelled</td>
<td>An authorization request has been submitted, but was cancelled by the health plan (e.g., duplicate request).</td>
</tr>
<tr>
<td>Denied</td>
<td>An authorization request has been submitted to the health plan, but has been denied.</td>
</tr>
<tr>
<td>Modified</td>
<td>The health plan has updated the status on one or more of the requested services on a previously submitted request.</td>
</tr>
<tr>
<td>Pending</td>
<td>An authorization request has been submitted to the health plan and is pending determination.</td>
</tr>
<tr>
<td>Authorization not required</td>
<td>The health plan’s response indicates that no authorization is required based on the member and criteria submitted.</td>
</tr>
</tbody>
</table>

Note: When viewing a Home Health authorization through Authorization Inquiry, you may notice the Sub-Type Code description differs from the Sub-Type Code description returned at the time of the original Authorization Submission. This variance has no impact on the authorization or claims processing.

Sample Authorization Submission Confirmation Screen:

Sample Authorization Inquiry Detail Screen:
The table below outlines the language variance between the two screens.

<table>
<thead>
<tr>
<th>Authorization Submission confirmation screen</th>
<th>Authorization Inquiry details screen view</th>
</tr>
</thead>
<tbody>
<tr>
<td>0590 – Dietician</td>
<td>0590 – GENERAL CLASSIFICATION-UNITS OF SERVICE – GENERAL CLASSIFICATION</td>
</tr>
<tr>
<td>780 – Home Uterine Monitor</td>
<td>0780 – TELEMEDICINE – GENERAL CLASSIFICATION</td>
</tr>
<tr>
<td>0551 – Skilled Nursing</td>
<td>0551 – SKILLED NURSING – CHARGE BY VISIT</td>
</tr>
<tr>
<td>0571 – Home Health Aide</td>
<td>0571 – HOME HEALTH AIDE (HOME HEALTH) – VISIT CHARGE</td>
</tr>
<tr>
<td>0431 – Occupational Therapy</td>
<td>0431 – OCCUPATIONAL THERAPY – VISIT CHARGE</td>
</tr>
<tr>
<td>0421 – Physical Therapy</td>
<td>0421 – PHYSICAL THERAPY – VISIT CHARGE</td>
</tr>
<tr>
<td>0581 – Prenatal Nursing</td>
<td>0581 – HOME HEALTH VISIT – VISIT CHARGE</td>
</tr>
<tr>
<td>0441 – Speech Therapy</td>
<td>0441 – SPEECH-LANGUAGE PATHOLOGY – VISIT CHARGE</td>
</tr>
<tr>
<td>0561 – Social Work</td>
<td>0561 – MEDICAL SOCIAL SERVICES – VISIT CHARGE</td>
</tr>
</tbody>
</table>

Another item to note when viewing an authorization is the Effective date that displays on the right side in the status ribbon. This will be displayed on Outpatient/Office authorizations. This value represents the date of service and will match the Date of Service found under the Servicing Provider section:
Amending an Authorization

You have the ability to amend existing authorizations through the Authorization Log.

At this time, amendment requests are restricted to authorizations that originated through the new NaviNet transaction. If the authorization was submitted through the legacy NaviNet transaction or by calling our Care Management team, you will not be able to submit the amendment request through NaviNet.

Note: Only the ADD functionality will be available at the time of the initial release. AMEND and EXTEND features will be introduced at a later time.

Submission of an amendment request to extend the service end date of existing approved service lines is permitted for outpatient services in an Approved or Modified status. The service end date cannot be extended more than one time for five days.

The following Service Types can be amended by extending the service end date:

- Ambulance (Land)
- Chemotherapy
- Infusion Therapy
- Durable Medical Equipment (rental only)
- Home Health
- Home Infusion

You can add a new service line in the following situations:

- the existing authorization is in a Pending, Approved or Modified status;
- services are in an outpatient, office, or home setting;
- you are adding a NEW service to an existing authorization;
- you are requesting more Visits/Days/Units for an existing service for a newly defined time period.

Only the following Service Types allow the ADD capability:

- Ambulance (Land)
- Chemotherapy
- Infusion Therapy
- Durable Medical Equipment – Purchase and Rental
- Home Health
- Home Infusion
To initiate an amendment request from the Authorizations Search Results screen, hover your mouse over the specific authorization and select the *Amend* link.

You will then be redirected to the Amend Authorization screen.

To initiate an amendment request from the Authorization Details screen, select the *Amend* link at the top of the screen above the status bar.
Adding a New Service

At the bottom of the screen you can add a new service line by selecting the button. The following screen is returned and you will be prompted to enter details of the new service including:
a. from date
b. procedure code
c. units
d. visit/dates
e. When complete, select Save.

Your new service line will appear. Additional service lines can be added as needed.
Extending a Service
To submit a request to amend the service end date, hover your mouse over the service line to reveal the Amend Dates option, then select Amend Dates.

Enter the new service end date in the field labeled To. When complete, select Save.

When you have finished adding new services or amending service end dates, select Submit to send your changes to the health plan.

If you have questions about the authorization submission and inquiry transactions, call the eBusiness Hotline at 215-640-7410.

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