centrix
BENEFIT ADMINISTRATORS

DOCUMENTATION REQUIRED FOR AUTHORIZATIONS ON PROCEDURES EXCEEDING $1000 BILLED

Patients covered under the Employee Benefit Plan are enrolled in a self-insured health plan sponsored through the Employee Benefit Trust. This Plan follows the rules of the Employee Retirement Income Security Act of 1974 (ERISA) and is considered a "grandfathered" plan under the Affordable Care Act (ACA).

The Plan's rules for eligibility, benefits, and operations are outlined in its official Plan Document. Centrix Benefit Administrators, Inc. ("Centrix") serves as the third-party administrator and manages the Plan on behalf of Employee Benefit Trust.

The Plan has specific rules about what medical procedures it covers. For a service to be eligible for coverage, especially elective procedures, it must meet the Plan's definition of "Covered Expenses." These are costs that are:

- Ordered by a physician (though this doesn't guarantee coverage), and
- Medically necessary for diagnosing or treating an illness or injury, as defined by the Plan.

Any elective procedure billed over $1000 **must** be pre-approved before the procedure is done. To get pre-authorization, the following documents may be faxed to Centrix:

1. Patient medical records
2. Referring physician's notes/order
3. Location of the procedure
4. CPT codes
5. Diagnosis codes
6. Estimated costs (facility and professional)

Please note: If pre-authorization is not obtained before the service is provided, the claim may be denied—even if the procedure is medically necessary.

Additionally, failure to submit all requested documentation, including pricing, will result in the delay of the authorization request being reviewed or processed.

817 Bowsprit Road, Ste 200 ○ Chula Vista, CA 91914 ○ Phone (800) 585-5965 ○ Fax (619) 220-9003

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BENEFIT ADMINISTRATORS

Representative: _____ Call Reference No. _____

Ph: (800) 585-5965 or (619) 220-9002
P.O. Box 212199, Chula Vista, California 91921

Group: _____

Prior Authorization Request Form

SECTION 1

Member Information

Group Name	Subscriber	Date
Patient	Dependent	Member I.D. #

Provider Information

Provider	Point of Contact	Tax I.D.
Specialty	Phone	Fax #
Procedure	Facility	

Required Documents

○ 1. Current Clinical Progress Notes	Notes:
○ 2. Requisition Order from Physician including **ICD10** and **CPT Codes**	Notes:
○ 3. Prior Diagnostic Results	Notes:
○ 4. Pricing **for both** facility and professional	Notes:
○ 5. Location of the procedure	Notes:

Failure to submit all required documentation may result in a delay in the timely review of the prior authorization request.

SECTION 2 INTERNAL USE ONLY

Medical Review

Date Sent	Disposition

Comments

SECTION 3 INTERNAL USE ONLY

Formal Notification to Provider

Was Procedure Authorized?	Terms
Was Provider Advised?	Contact

Formal Notification to QVI

Date Advised