TO: **Inpatient Hospitals, Outpatient Hospitals, Extended Care Facility/Chronic Inpatient, Home Health Care, DME/Medical Supply Department, Hospice Agency, Laboratory, Radiology, Therapists, Therapist Groups, APRN, APRN Group, Physician, Physician Group, Optometrist, Optician, Optometrist Group, Optician Group, Podiatrist, Podiatrist Group, Nurse Midwife & Nurse Midwife Group**

RE: **Authorization For Clients With Other Insurance (OI) or Medicare**

The purpose of this bulletin is to notify providers that effective **May 1, 2014 and forward** authorization requirements for clients that have Other Insurance (OI) will change. If a client has OI, providers **are required to obtain authorization prior to** the service being rendered. However, if a client has Medicare as their primary insurance, prior authorization (PA) is not required, as per current policy.

Dates of services *prior* to May 1, 2014, may still be submitted to Community Health Network of Connecticut (CHNCT) or Care to Care for Radiology authorizations for retrospective review if the OI denied or paid less than the Medicaid rate. Providers should submit a completed PA form, the Explanation of Benefits (EOB) from the primary insurance, and the medical records to substantiate the medical necessity of the requested service. PA will be authorized retroactively on a case by case basis, and if approved, the PA will be backdated to the date of service.

For questions regarding the prior authorization process, please contact CHNCT at 1-800-440-5071, Monday through Friday between the hours of 8:00 a.m. and 7:00 p.m. Information on the Prior Authorization process can also be found in Chapter Nine of the Provider Manuals. Go to the Home page of www.ctdssmap.com Web site and select "Information" → "Publications" → scroll down to "Provider Manuals" and choose "Chapter 9 Prior Authorization".