

| MANAGED CARE PRIOR AUTHORIZATION REQUIREMENTS | |
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| Hospitalization - Excludes 48/96 hour (legislated timeframe for delivery) maternity admissions | Yes |
| Non-Emergency Inpatient surgical procedures | Yes |
| Skilled Nursing Facility Stays | Yes |
| Rehabilitation Facility Stays | Yes |
| Outpatient Services | Precert Yes/No |
| Outpatient Surgical Procedures – Excludes colonoscopies, endoscopies and surgeries performed in an office setting | Yes |
| Cardiac Rehabilitation Therapy | Yes |
| Behavioral Health Services | Precert Yes/No |
| Inpatient BH/SA | Yes |
| Other BH/SA Services | |
| Intensive Outpatient Therapy | (IOP) if covered. Check the benefits section for coverage. |
| | Yes |
| Partial Hospitalization (PHO) | if covered. Check the benefits section for coverage |
| Residential Care (RTC) | if covered. Check the benefits section for coverage |
| Other | Precert Yes/No |
| Transplants | Yes |
| Home Health Care | Yes |
| Durable Medical Equipment (over \$1,500) | Yes |
| Genetic Testing/Molecular Pathology | Yes |
| Prosthetics and Orthotics (over \$750) | Yes |
| Sleep Disorder Testing | Yes |
| Infusion Therapy | Yes |
| Radiation Therapy | Yes |
| Advanced Imaging Services (MRI/MRA/CAT/PET/SPECT/Diagnostic mammograms) - Excludes preventive low dose CT scans | Yes |
| Specialty Pharmacy | Yes |