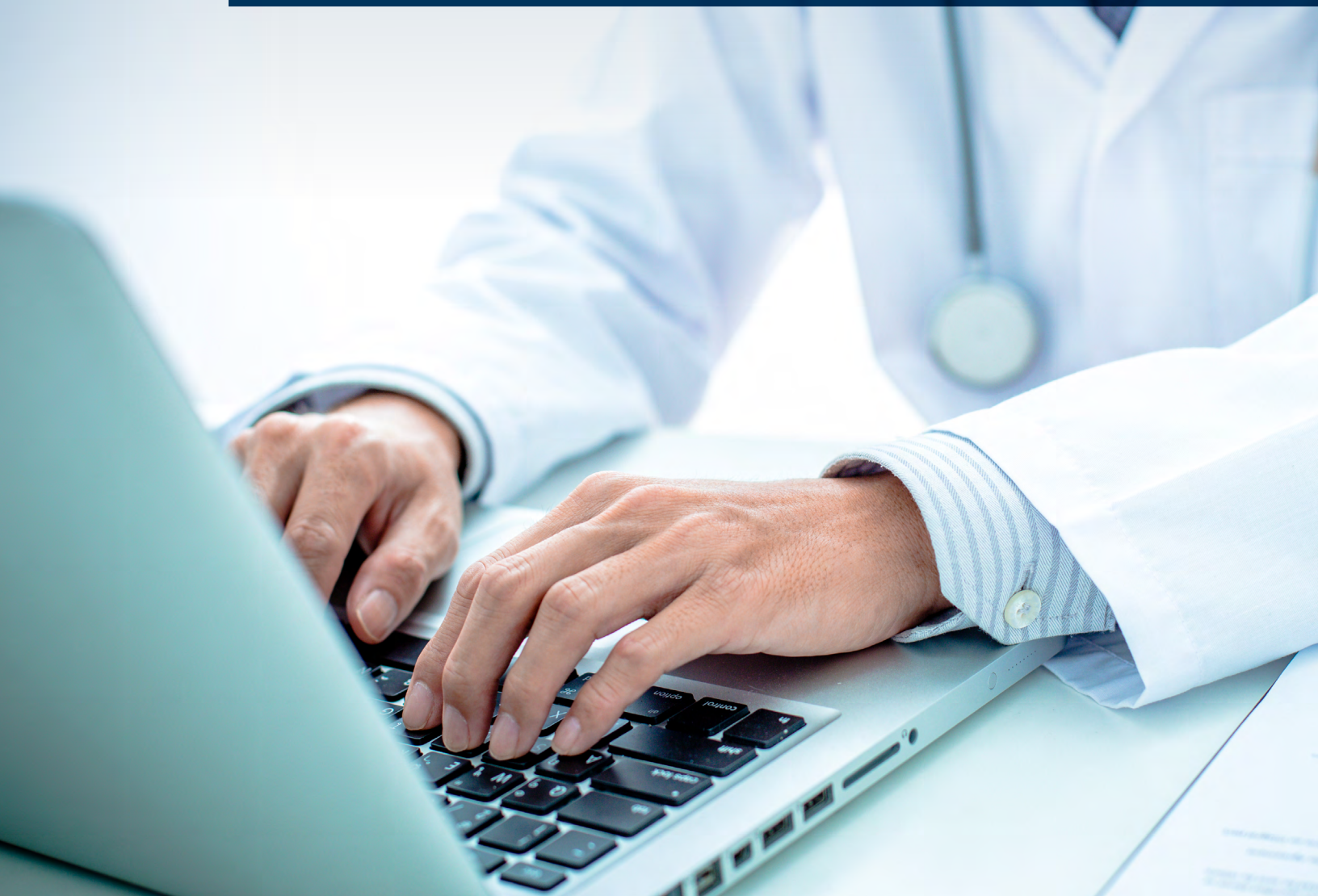


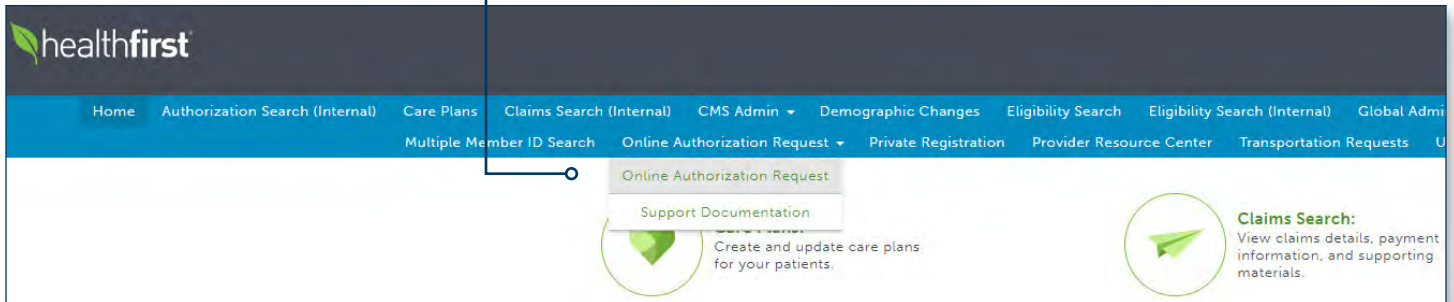
# Healthfirst Provider Portal: Guide to Using the Online Authorization Request Tool

The Online Authorization Request tool is a feature on the Healthfirst Provider Portal at [hfproviderportal.org](https://hfproviderportal.org) that allows you to enter an authorization request online. You can enter clinical details for an authorization request and submit clinical documents that support your request.



# How to Generate an Online Authorization Request

- 1 Log in to the Provider Portal at [hfproviderportal.org](https://hfproviderportal.org) with your Username and Password.
- 2 Click on the **Online Authorization Request** tab and select **Online Authorization Request** from the dropdown.



- 3 Once on the Authorization Request tab, click **Begin**.


Use this guided process to submit your request for authorization of services or supplies.

For requests that require immediate attention, please call Healthfirst Provider Services at 1-888-394-4327.

You will need the following information to complete your request:

- Member's name, Healthfirst ID, and Date of Birth
- Type of service
- Place of service
- Date(s) of service
- Provider/Facility name(s) and Tax IDs or NPIs
- Contact information
- Diagnosis & Procedure/Service code(s)
- Supporting clinical documentation

**Begin**

 You may have received a request for information on an existing authorization. Please go to the My Requests tab and click on the "Request for Information" button.

- 4 Enter the member's **Healthfirst Member ID**, **Date of Birth**, and **Last Name**. (First name is optional.) Click **Search**.

The screenshot shows a five-step process bar at the top: 1. Member (highlighted), 2. Request Details, 3. Rendering Provider, 4. Referring provider, and 5. Facility. Below the bar is the 'Search For Member' form. It includes fields for Healthfirst Member ID (Max. 15 characters), Date of Birth (mm/dd/yyyy), Last Name (Enter at least first 2 letter), and First Name (Max. 24 characters). A green 'Next >>' button is at the bottom left, and an orange 'Search' button is at the bottom right.

Once the member's details display, click **Next**.

To exit the request at any time, click **Cancel Request**.

This screenshot shows the 'Search For Member' form after a search. The search fields are populated with: Healthfirst Member ID 'XX1234D', Date of Birth '11/23/1941', Last Name 'Smith', and First Name (empty). The orange 'Search' button is visible. Below the search fields is a 'Member Details' section containing a table with the following data:

Healthfirst Member ID	Date of Birth	Benefit Plan Name	Benefit Plan Description	Effective Date	Termination Date
XX1234D	11/23/1941	MEDICARE PLAN	LIFE IMPROVEMENT PLAN	02/01/2016	

Below the table, a row of request details is displayed: XX30355D, ARQ-73403, OP0003702254, Approved, 11/30/20 3:39 PM, and 11/30/20 3:56 PM. At the bottom, there is a green 'Next >>' button and a 'Cancel Request' button.

- 5 Select the Level of Urgency: **Standard Request** or **Expedited Request**  
Select the Request Type: **Inpatient** or **Outpatient**  
Click **Next**.

**Request Type**

Please select a request type and enter additional information:


\* Required

Benefit Plan Name  
**MEDICARE PLAN**

Level of Urgency  
☒ Standard request  
☐ Expedited request

\* Request Type  
☐ Inpatient  
☐ Outpatient

<< Back      Next >>

- 6 For Outpatient Requests, enter the **Start Date of Service** and **End Date of Service**.  
The start date must be no earlier than today's date.
- The **90 Days** and the **180 Days** options will prepopulate the end date.
- For help, click on the **Question Mark**  icon.

Authorization Request for:

**JANE DOE**

Member ID: 116064731    Date of Birth: 11/23/1941    Request Type: Outpatient

**Request Type**

Please select a request type and enter additional information:

\* Required

Benefit Plan Name  
**MEDICARE PLAN**

Level of Urgency  
☒ Standard request  
☐ Expedited request

\* Request Type  
☐ Inpatient  
☒ Outpatient


\* Start Date of Service  
12/3/2020


\* End Date of Service  
mm/dd/yyyy

☐ 90 Days  
☐ 180 Days



?




- 7 Enter at least one primary diagnosis in **Diagnosis Information**.  
You can enter up to three more diagnoses. Click **Add Diagnosis**.  
To change or remove a code, click the  icon.

**Diagnosis Information** 

\* Required

 Enter at least 3 characters to search for diagnosis by code or description 

Please add up to 3 additional diagnoses.

	Code	Description	
1	A90	DENGUE FEVER [CLASSICAL DENGUE]	

Enter the **Authorization Type**, **Place of Service**, **Procedure Code**, and **Keyword**.  
Click **Add Code**.

**Procedure Information**


\* Required

Please select up to 25 procedure/service code(s).

	Authorization Type	Place of Service	Procedure Code	Requested Units	Unit Type	Servicing Facility
1	DURABLE MEDICAL EQUIPMENT	HOME	E2300	1	Units	

\* Authorization Type  \* Place of Service

**PROCEDURE INFORMATION**

Code	Description	* Requested Units	* Unit Type	
E2300	POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM	<input type="text" value="1"/>	<input type="radio"/> Days <input checked="" type="radio"/> Units	

Enter the **Requested Units** and the **Unit Type**.


**Line Item Details**

Please select up to 25 procedure/service code(s).

	Authorization Type	Place of Service	Procedure Code	Requested Units	Unit Type	Servicing Facility
1	DURABLE MEDICAL EQUIPMENT	HOME	E2300			

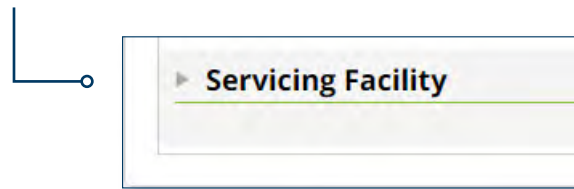
\* Authorization Type  \* Place of Service

**PROCEDURE INFORMATION**

Code	Description	* Requested Units	* Unit Type	
E2300	POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM	<input type="text"/>	<input type="radio"/> Days <input checked="" type="radio"/> Units	

► Servicing Facility

8 To add a **Servicing Facility**, click the **arrow** to display search criteria.



Enter the **Facility Name**, **Tax ID (TIN)**, and **National Provider Identifier (NPI)**. (Zip Code and Healthfirst Provider ID are optional.) Click **Search**.

A screenshot of the 'Servicing Facility' search form. It includes a dropdown menu for 'Servicing Facility', a search bar, and several input fields: 'Facility Name' (with a hint 'Enter at least 2 characters'), 'National Provider Identifier (NPI)' (with a hint '9 digits'), 'Tax ID' (with a hint '9 digits'), 'Zip Code' (with a hint '5 digits'), and 'Healthfirst Provider ID' (with a hint '16 characters'). A blue line with a circle at the end points to the 'Search' button.

Facility Name	National Provider Identifier (NPI)	Tax ID	Zip Code	Healthfirst Provider ID
Enter at least 2 characters	<input type="radio"/>	<input checked="" type="radio"/>	5 digits	16 characters

If multiple facility options display, click **Select** next to the provider address where services will be rendered. Click **Submit**.

A screenshot of the 'FACILITY ADDRESS' table. The table has columns: Name, Address, Zip Code, NPI, Tax ID, Provider ID, Participating, and a 'Select' button. There are three rows of data. A blue line with a circle at the end points to the 'Select' button in the third row. Another blue line with a circle at the end points to the 'Submit' button at the bottom right of the table.

Name	Address	Zip Code	NPI	Tax ID	Provider ID	Participating	Select
BREATHING EQUIP	456 ABCD Street	11021	987654321	12345678	123456-003	Yes	Select
BREATHING EQUIP	PO BOX 1234	19182	678901234	12345678	123456-001	No	Select
BREATHING EQUIP	123 ABCD Street	10952	123456789	12345678	123456-002	No	Select

9 To add procedure information, click the **Add Line Item** link.

**PROCEDURE INFORMATION**

Code: E2300 Description: POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM

Requested Units: 1 Unit Type: Days Units

Only one servicing facility can be added per line. To change the provider, remove it and search for a different servicing facility.

**Servicing Facility**

Name	Address	Zip Code	NPI	Tax ID	Healthfirst Provider ID	Participating
BREATHING EQUIP	31 Rian Drops DR	11021	123456790	12345679	12345679-411	Yes

[Add Line Item](#)

10 Enter the **Rendering Provider Name**, **Tax ID (TIN)**, and **National Provider Identifier (NPI)**. (Zip Code and Healthfirst Provider ID are optional.) Click **Next**.

**RENDERING PROVIDER**

Name: MEMBER'S PCP SELECTED Address: Zip Code: NPI: Tax ID: Healthfirst Provider ID: 123456-ABC

**CONTACT INFORMATION**

First Name: Jane Last Name: Doe Telephone: 123-456-7890 Extension: 1234567 Fax: 123-456-7890 Email Address:

<< Back Next >>

If multiple provider options display, click **Select** next to the provider address where services will be rendered. Click **Submit**.

**Rendering Provider Address**

Select the address where the services will be provided

3 providers found

Name	Address	Zip Code	NPI	Tax ID	Provider ID	Participating
BREATHING EQUIP	456 ABCD Street	11021	987654321	12345678	123456-003	Yes
BREATHING EQUIP	PO BOX 1234	19182	678901234	12345678	123456-001	No
BREATHING EQUIP	123 ABCD Street	10952	123456789	12345678	123456-002	No

Cancel Submit

- 11** Select **Use Member's Primary Care Physician (PCP)?** if the Rendering Provider is their PCP.

**Rendering Provider**

**\* Required**

☐ Use Member's Primary Care Physician (PCP)?

☐ National Provider Identifier (NPI)  
☐ Tax ID

**\* Provider Last Name or Facility Name**  **987654321** **Zip Code**  **Healthfirst Provider ID**  **Search**

Enter **First Name**, and **Telephone** and **Fax** numbers, for a direct clinical contact. (Last Name, Extension, and Email are optional.) Click **Next**.

**RENDERING PROVIDER**

Name Address Zip Code NPI Tax ID Healthfirst Provider ID

MEMBER'S PCP SELECTED

**CONTACT INFORMATION**

First Name Last Name \* Telephone Extension \* Fax Email Address

**<< Back** **Next >>**

- 12** The Prescreen displays whether an authorization is required, is a duplicate, or is managed by a delegated vendor. Additional action(s) may be required based on Prescreen results. Click **Next**.

**Diagnosis Information** [Edit this information](#)

Description

1 S94.92XD-INJURY OF UNSPECIFIED NERVE AT ANKLE AND FOOT LEVEL, LEFT LEG, SUBSEQUENT ENCOUNTER

**Procedure Information** [Edit this information](#)

1	Authorization Type	Place of Service	Rendering Provider	Procedure Code	Requested Units	Unit Type
1	DURABLE MEDICAL EQUIPMENT	NURSING FACILITY	MEMBER'S PCP SELECTED	E2301	1	Units
Is member eligible?				ELIGIBLE		
Is authorization required?				YES Reason: Procedure code requires auth		
Is authorization duplicate?				NO		

2	Authorization Type	Place of Service	Rendering Provider	Procedure Code	Requested Units	Unit Type
2	ADULT DAY HEALTH CENTER	NURSING FACILITY	MEMBER'S PCP SELECTED	00500	2	Units
Is member eligible?				ELIGIBLE		
Is authorization required?				NO		
Is authorization duplicate?				NO		
Authorization is not required for this Service or Procedure. To continue, please remove code. For questions, please call 1-888-394-4327.						

3	Authorization Type	Place of Service	Rendering Provider	Procedure Code	Requested Units	Unit Type
3	ADULT DAY HEALTH CENTER	NURSING FACILITY	MEMBER'S PCP SELECTED	37722	1	Units
Is member eligible?				ELIGIBLE		
Is authorization required?				YES Reason: Refer to Orthonet		
Is authorization duplicate?				NO		

authorization is not required for some of the procedure codes. Your reference number is ARQ-73397. To print a confirmation, please click [here](#).

**<< Back** **Next >>** **Cancel Request**



**13** Enter Referring Provider's **Name**, **Tax ID (TIN)**, and **National Provider Identifier (NPI)**. (Zip Code and Healthfirst Provider ID are optional.) Click **Search**.

Click **Same as Rendering Provider** if the Referring Provider is the Rendering Provider.

Click **Use Member's Primary Care Physician (PCP)?** if the Referring Provider is their PCP.

Click **Next**.

1 Member 2 Request Details 3 Prescreen 4 Referring provider 5 Documentation 6 Review

Authorization Request for:  
**Jane Doe**

Member ID: **XX12345Z** Date of Birth: **11/23/1941** Request Type: **Outpatient** Rendering Provider: **MEMBER'S PCP SELECTED**

▼ **Select Referring Provider**

☒ Same as Rendering Provider?  
☐ Use Member's Primary Care Physician (PCP)?

**Referring Provider**

Name	Address	Zip Code	NPI	Tax ID	Healthfirst Provider ID
MEMBER'S PCP SELECTED					<b>H12345-AB</b>

**Contact Information**

Please provide the following contact information for the Referring Provider.

\* indicates required field

First Name:  Last Name:  \* Telephone:  Extension:  \* Fax:  Email Address:  [Address Book](#)

<< Back Next >>

**14** Click **Add An Attachment** to attach clinical documentation to the request.

Please note: [Click here for a list of preferred file types.](#) Uploaded files are limited to 5MB in size.

**Add An Attachment**

Add Attachment(s)

**Existing Attachments**

File Name	Document Type	Attached By
No attachments		

<< Back   Next >>

Click **Select file(s)** or use **Drag and Drop** to upload clinical documentation.

Select **Document Type** from dropdown if different from Medical Records.

Click **Attach**.

**Add Attachment(s)**

Drag and drop files here

or

Select file(s)

FILE NAME	DOCUMENT TYPE *
Auth Required Doc.txt	MEDICAL RECORDS

Cancel   Attach

Documents will display under **Existing Attachments**. If the document does not appear, the document will not accompany the authorization request and processing may be delayed.

To remove a document, click the **Trash Can** icon.

## 15 Validate the authorization details on the Review Page.

Authorization Request for: **Jane Doe** Date of Request: 11/30/2020

Member ID: **XX123452** Date of Birth: **11/23/1941** Request Type: **Outpatient** Rendering Provider: **MEMBER'S PCP SELECTED** Reference Number: **ARQ-73397**

---

**Authorization Request** **Provider** **Member**

To modify any information on this page, click on the numbered circles above or click "Edit this information" in each section.

**Summary** [Edit this information](#)

Auth Reference Number: ARQ-73397	Request Date: 11/30/2020	Request Type: Outpatient	Start Date of Service: 11/30/2020	End Date of Service: 02/28/2021
-------------------------------------	-----------------------------	-----------------------------	--------------------------------------	------------------------------------

**Diagnosis Information** [Edit this information](#)

Description

- 594.92XD-INJURY OF UNSPECIFIED NERVE AT ANKLE AND FOOT LEVEL, LEFT LEG, SUBSEQUENT ENCOUNTER
- A90-DENGUE FEVER [CLASSICAL DENGUE]

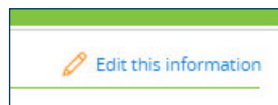
**Procedure Information - Auth Required** [Edit this information](#)

Authorization Type	Place of Service	Procedure Code	Requested Units	Unit Type
DURABLE MEDICAL EQUIPMENT	NURSING FACILITY	E2301-POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM	1	Units

1 BREATHING EQUIP

Name	Address	Zip Code	City	State	Healthfirst Provider ID
BREATHING EQUIP	PO BOX 1234	19182	678901234	12345678	123456-001

Click **Edit this information** to change or correct details before submission.



Click **Submit** to acknowledge that the authorization request is NOT an expedited request.

By clicking Submit, you acknowledge this is NOT an expedited request.  
Expedited requests must be submitted by calling Healthfirst at 1-888-394-4327.

[Back](#) [Submit](#)

## 16 Once the Submit button is clicked, an **Authorization Request number** will be displayed.

Authorization Request for: **Jane Doe**

Member ID: **XX123452** Date of Birth: **11/23/1941** Request Type: **Outpatient** Rendering Provider: **MEMBER'S PCP SELECTED**

Your Authorization Request was submitted successfully. Your Authorization Request number is **OP0003702116**. Please allow 24-48 hours for us to address your request. Please note that submissions require review and do not guarantee approval. To request additional services, you must submit an additional authorization request.

**WHAT WOULD YOU LIKE TO DO NEXT?**

**Print your confirmation** **Print a fax cover sheet** **Create new request** **Copy this request** **Return home**

# My Requests Tab

- 1 To review requests submitted via the online authorization tool, return to the Welcome Page and select the **My Requests** tab.

Authorization Request      My Requests      Support Documentation

Use this guided process to submit your request for authorization of services or supplies.

For requests that require immediate attention, please call Healthfirst Provider Services at 1-888-394-4327.

You will need the following information to complete your request:

- Member's name, Healthfirst ID, and Date of Birth
- Type of service
- Place of service
- Date(s) of service
- Provider/Facility name(s) and Tax IDs or NPIs
- Contact information
- Diagnosis & Procedure/Service code(s)
- Supporting clinical documentation

**Begin**

**You may have received a request for information on an existing authorization. Please go to the My Requests tab and click on the "Request for Information" button.**

- 2 When navigating to the **My Requests** tab, a grid with several columns and a row for each specific authorization request created will be displayed.

For each authorization, you will see the following:

- Member Name
- Member ID
- Authorization Reference Number
- Authorization Request Number
- Authorization Status
- Authorization Creation/Submission Date
- Authorization Update Date (if applicable)

*The grid will show 10 requests per page. You can view additional pages by clicking on the page or arrow located at the top right of the grid.*

CHOOSE A REQUEST TYPE

☒ Authorization Requests      ☐ Support Documents      ☐ Request for Information (RFI)

Below is a list of authorization requests that you have submitted online.

Please note that the requests listed below have been submitted, but submission does not mean the request has been reviewed or approved. For a complete list of authorization requests or to check the status of a request, [click here to go to the Authorization Search tab](#). Please allow 24-48 hours after submission to check your Authorization status on the Provider Portal.

Select the row below for a read-only view of your submitted authorization request.

SELECT	MEMBER NAME	MEMBER ID	AUTH REFERENCE	AUTH REQUEST NUMBER	AUTH STATUS	CREATED / SUBMITTED DATE	UPDATED DATE	PRINT FAX COVER SHEET
<input type="radio"/>	Doe, Jane	AB12345	ARQ-73403	OP0003702254	Approved	11/30/20 3:39 PM	11/30/20 3:56 PM	
<input type="radio"/>	Doe, Jane	AB12345	ARQ-73396	OP0003701963	Pending	11/30/20 2:59 PM	11/30/20 3:01 PM	
<input type="radio"/>	Doe, Jane1	AB12346	ARQ-73342	OP0003698198	Pending	11/30/20 8:16 AM	11/30/20 8:24 AM	

1 2 3 4 5 6 7 8 9 10...

3 For a specific authorization, click the button under the **Select** column.

SELECT	MEMBER NAME	MEMBER ID	AUTH REFERENCE	AUTH REQUEST NUMBER	AUTH STATUS	CREATED / SUBMITTED DATE	UPDATED DATE	PRINT FAX COVER SHEET
<input type="radio"/>	Doe, Jane	XX123456	ARQ-73403	OP0003702254	Approved	11/30/20 3:39 PM	11/30/20 3:56 PM	
<input type="radio"/>	Doe, Jane	XX123456	ARQ-73396	OP0003701963	Pending	11/30/20 2:59 PM	11/30/20 3:01 PM	
<input type="radio"/>	Doe, Jane S.	12334567	ARQ-73342	OP0003698198	Pending	11/30/20 8:16 AM	11/30/20 8:24 AM	

4 If you have selected a specific authorization, click on one of these three tabs to view authorization details:

#### Authorization Request Tab

- Diagnosis Information
- Procedure Information (with facility details, if applicable)
- File Attachments

Authorization Request

Provider

Member

**Summary**

Auth Request Number  
OP0003729451

Request Date  
11/30/2020

Request Type  
Outpatient

Method  
Web

Level Of Urgency  
Standard Pre-Auth

Authorization Comments

Service Frequency Notes  
[View](#)

**Diagnosis Information**

Description

1 A00.0 - CHOLERA DUE TO VIBRIO CHOLERAE 01, BIOVAR CHOLERAE

**Procedure Information - Auth Required**

Authorization Type HOSPICE	Place of Service HOSPICE	Procedure Code L3999 UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED	Requested Units 1	Unit Type Units
1				
SERVICING FACILITY				
Name BREATHING EQUIP	Address 123 ABCD Street	Zip Code 10952	NPI 123456789	Tax ID 12345678
				Healthfirst Provider ID 123456-002

**Attachments**

Show Document Received Date

File Name	Document Type	Attached By
No attachments		



## 5 Provider Tab

- Rendering Provider Details
- Referring Provider Details
- Contact Information

[Print Request](#) This Authorization cannot be updated

Authorization Request		Provider				Member
<b>Rendering Provider</b>						
Name	Address	Zip Code	NPI	Tax ID	Healthfirst Provider ID	
MEMBER'S PCP SELECTED					224450-C19	
<b>CONTACT INFORMATION</b>						
First Name	Last Name	Telephone	Extension	Fax	Email Address	
		111-111-1111		111-111-1111		
<b>Referring Provider</b>						
Name	Address	Zip Code	NPI	Tax ID	Healthfirst Provider ID	Participating
COLLINS, INYANGA L	1276 FULTON AVE FL 3 BRONX NY	10456	1073501987	131974191	224450-C19	Yes
<b>CONTACT INFORMATION</b>						
First Name	Last Name	Telephone	Extension	Fax	Email Address	
		111-111-1111		111-111-1111		




## 6 Member Tab

- Member Details
- Coverage Information

**SELECTED AUTHORIZATION REQUEST** [Print Request](#)

Authorization Request		Provider	Member
<b>Member Details</b>			
Healthfirst Member ID	Date of Birth	Last Name	First Name
XX123456	10/26/1962	Doe	Jane
<b>Coverage Information</b>			
Benefit Plan Name	Benefit Plan Description	Effective Date	Termination Date
Life Improvement Plan (HMO SNP)	LIFE IMPROVEMENT PLAN	11/01/2019	

- 7 Click the **Printer** icon in the **Print Fax Cover Sheet** column to generate a prepopulated cover sheet.

SELECT	MEMBER NAME	MEMBER ID	AUTH REFERENCE	AUTH REQUEST NUMBER	AUTH STATUS	CREATED / SUBMITTED DATE	UPDATED DATE	PRINT FAX COVER SHEET
<input type="radio"/>	Doe, Jane	XX123456	ARQ-73403	OP0003702254	Approved	11/30/20 3:39 PM	11/30/20 3:56 PM	
<input type="radio"/>	Doe, Jane	XX123456	ARQ-73396	OP0003701963	Pending	11/30/20 2:59 PM	11/30/20 3:01 PM	
<input type="radio"/>	Doe, Jane S.	12334567	ARQ-73342	OP0003698198	Pending	11/30/20 8:16 AM	11/30/20 8:24 AM	

- 8 Click **Print Request** to generate a PDF of the selected Authorization Request.

Print Request

This Authorization cannot be updated

Authorization Request

Provider

Member

