

Individual had exacerbations requiring oral systemic corticosteroid use greater than or equal to 2 per year

(2) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

Pre-Claim

Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

____ / ____ / ____
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.