



OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Standard Requests: **Fax** 877-650-6943
Transplant Requests: **Fax** 833-589-1239

Request for additional units. Existing Authorization Units

Standard requests - Determination within 3 calendar days and/or 2 business days of receiving all necessary information

Expedited requests - I certify that following the standard authorization decision time frame could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Medicaid/Member ID*

Last Name, First

Date of Birth*

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI*

Requesting TIN*

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax*

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI*

Servicing TIN*

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code*

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Start Date OR Admission Date*

(MMDDYYYY)

Diagnosis Code*

(ICD-10)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

End Date OR Discharge Date*

(MMDDYYYY)

Total Units/Visits/Days

OUTPATIENT SERVICE TYPE*

(Enter the Service type number in the boxes)

- | | |
|----------------------------------|-------------------------------|
| 412 Auditory Services | 290 Hyperbaric Oxygen Therapy |
| 422 Biopharmacy | 729 Neuropsych Testing |
| 401 Cardiac/Pulmonary Rehab | 410 Observation |
| 712 Cochlear Implants & Surgery | 790 Occupational Therapy |
| 299 Drug Testing | 210 Orthotics |
| 205 Genetic Testing & Counseling | 794 Outpatient Services |
| 249 Home Health | 171 Outpatient Surgery |
| 390 Hospice Services | 202 Pain Management |
| 201 Sleep Study | 650 Radiation Therapy |
| 701 Speech Therapy | 101 Physical Therapy |
| 472 Stereotactic Radiosurgery | 147 Prosthetics |
| 724 Transportation | 993 Transplant Evaluation |
| | 209 Transplant Surgery |

DME

417 Rental
120 Purchase
(Purchase Price)

Outpatient Services Example:
- Skin Debridement/Wound Care

Outpatient Surgery Examples:
- Hysterectomy
- Mammoplasty
- Rhino/Septoplasty

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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