magnolia health

# OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 1-877-650-6943

☐ 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
422 Biopharmacy
712 Cochlear Implants and Surgery
771 Dialysis
299 Drug Testing
709 Genetic Testing
249 Home Health
799 Genetic Counseling
201 Sleep Study
701 Speech Therapy
472 Stereotactic Radiosurgery
724 Transportation
600 Home Infusion
290 Hyperbaric Oxygen Therapy
240 Inpatient Hospice
729 Neuropsych Testing
790 Occupational Therapy
443 Observation (non par only)
997 Office Visit/Consult (non par only)
210 Orthotics
927 Outpatient Hospice
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
101 Physical Therapy
147 Prosthetics

### 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.***



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