



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

		Date of Birth*
Medicaid/Member ID*	Last Name, First	(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*	Additional Procedure Code	Start Date OR Admission Date*	Diagnosis Code*
(CPT/HCPCS)	(Modifier)	(MMDDYYYY)	(ICD-10)
Additional Procedure Code	Additional Procedure Code	End Date OR Discharge Date*	Total Units/Visits/Days
(CPT/HCPCS)	(Modifier)	(MMDDYYYY)	

OUTPATIENT SERVICE TYPE*		(Enter the Service type number in the boxes)	
412 Auditory Services	290 Hyperbaric Oxygen Therapy		
422 Biopharmacy	240 Inpatient Hospice		
712 Cochlear Implants and Surgery	729 Neuropsych Testing		
771 Dialysis	790 Occupational Therapy		
299 Drug Testing	443 Observation (non par only)		
709 Genetic Testing	997 Office Visit/Consult (non par only)		
249 Home Health	210 Orthotics		
799 Genetic Counseling	927 Outpatient Hospice		
201 Sleep Study	794 Outpatient Services		
701 Speech Therapy	171 Outpatient Surgery		
472 Stereotactic Radiosurgery	202 Pain Management		
724 Transportation	101 Physical Therapy		
600 Home Infusion	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.**

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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