



OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 1-844-367-7022
Transplant Request **Fax** to: 1-833-414-1503

Request for additional units. Existing Authorization Units

Standard requests - Determination within 14 calendar days of receipt of request.

Expedited requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

* 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 & Surgery
- 299 Drug Testing
- 922 Experimental & Investigational Services
- 205 Genetic Testing & Counseling
- 249 Home Health
- 290 Hyperbaric Oxygen Therapy
- 395 Infertility Diagnosis or Treatment
- 410 Observation
- 997 Office Visit/Consult (non par only)

- 794 Outpatient Services
- 171 Outpatient Surgery
- 202 Pain Management
- 201 Sleep Study
- 472 Stereotactic Radiosurgery
- 993 Transplant Evaluation
- 209 Transplant Surgery

DME

- 417 Rental
- 120 Purchase (Purchase Price)

Therapy

- 212 Therapy Evaluation
- 790 Occupational Therapy
- 101 Physical Therapy
- 701 Speech Therapy

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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