WAIVER SERVICES AUTHORIZATION FORM

Complete and **fax** to: 1-833-249-2342

Request for additional units   Existing Authorization:

Standard request — Determination within two business days of receipt of all necessary information

Urgent request — I certify this request is urgent and medically necessary to treat an injury, illness or condition (non-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)

Units
(Modifier)

Start Date *OR Admission Date
(MMDDYYYY)

*Diagnosis Code
(ICD-10)

Procedure Code

End Date *OR* Discharge Date
(MMDDYYYY)

Procedure Code

Procedure Code

CES Waiver Services: Please check

New Waiver Services
Continuation of Services
Revision to current services
Increase
Decrease
Correction

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.

© 2021 Arkansas Total Care, Inc. All rights reserved.