



# OUTPATIENT MEDICAID AUTHORIZATION FORM

Complete and Fax to: 1-833-249-2342

Request for additional units. Existing Authorization Units

**Standard requests** - Determination within 5 calendar days of receipt of request.

**Urgent 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

\*Date of Birth

## MEMBER INFORMATION

\*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) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)

Additional Procedure Code Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)

### \*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

422 Biopharmacy	790 Occupational Therapy	<b>Behavioral Health</b>	<b>DME</b>
712 Cochlear Implants & Surgery	794 Outpatient Services	533 BH Applied Behavioral Analysis	417 Rental
299 Drug Testing	171 Outpatient Surgery	512 BH Community Based Services	120 Purchase (Purchase Price)
922 Experimental and Investigational Services	202 Pain Management	514 BH Day Treatment	
205 Genetic Testing & Counseling	101 Physical Therapy	515 BH Electroconvulsive Therapy	
249 Home Health	201 Sleep Study	516 BH Intensive Outpatient Therapy	
390 Hospice Services	701 Speech Therapy	510 BH Medical Management	
290 Hyperbaric Oxygen Therapy	472 Stereotactic Radiosurgery	518 BH Mental Health /Chemical Dependency Observation	
141 Imaging	993 Transplant Evaluation	519 BH Outpatient Therapy	
112 Nutritional Supplements and/or Services	209 Transplant Surgery	530 BH PHP	
	724 Transportation	520 BH Professional Fees	
	650 Radiation Therapy	521 BH Psychological Testing	

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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