absolute total care | Healthy Connections

OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 1-866-912-3606
Transplant Requests: **Fax** 1-833-414-1668
Behavioral Health Requests: **Fax** 1-833-493-3350

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ Standard Request - Determination within 14 calendar days of receiving all necessary information

☐ Urgent Request - Determination within 72 hours of receiving the request. I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

X _____ PHYSICIAN MUST SIGN FOR URGENT PRIORITY REVIEW. IF WE DO NOT HAVE THE PHYSICIAN'S SIGNATURE, IT WILL BE PROCESSED AS A STANDARD REQUEST.

***** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID/Medicaid 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)* ☐☐☐

410 Observation - Non PAR or PAR > 48 hours
412 Auditory
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
709 Genetic Testing
249 Home Health
395 Infertility Diagnosis or Treatment
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery

202 Pain Management
650 Radiation Therapy
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

417 DME - Rental
120 DME - Purchase
(Purchase or Monthly Rental Price)

Behavioral Health
510 BH Medical Management
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intenstive Outpatient Therapy
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation
530 BH Partial Hospitilization Program
533 BH Applied Behavioral Analysis

**** If you are requesting Biopharmacy(medications) please use the Prior Authorization Form on the ATC website****

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.