OUTPATIENT MEDICAID
PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 1-866-912-3606

☐ 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 ____________________ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

**** INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Date of Birth * (MMDDYYYY)

Member ID/Medicaid ID *

Last Name, First

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
401 Cardiac Pulmonary Rehab
924 Chiropractic
712 Cochlear Implants & Surgery

DME

417 Rental $ ________
120 Purchase (Purchase Price)

299 Drug Testing
922 Experimental and Investigational Procedure

709 Genetic Testing
249 Home Health
211 OB Ultrasound(s)
410 Observation
790 Occupational Therapy
497 Office Visit/Specialty Consult
927 Outpatient Hospice
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management

101 Physical Therapy
201 Sleep Study
701 Speech Therapy
724 Transportation

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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