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

- 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
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
709 Genetic Testing
249 Home Health
390 Hospice Services
395 Infertility Diagnosis or Treatment
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery

202 Pain Management
650 Radiation Therapy
201 Sleep Study
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

417 DME - Rental
120 DME - Purchase ____ (Purchase Price)

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.