



# 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.

**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)

- |   |                           |  |
|---|---------------------------|--|
| 412 Auditory                                  | 202 Pain Management       |  |
| 712 Cochlear Implants & Surgery               | 650 Radiation Therapy     |  |
| 299 Drug Testing                              | 201 Sleep Study           |  |
| 922 Experimental and Investigational Services | 993 Transplant Evaluation | 417 DME - Rental <input type="text"/> (Purchase or Monthly |
| 709 Genetic Testing                           | 209 Transplant Surgery    | 120 DME - Purchase <input type="text"/> Rental Price)      |
| 249 Home Health                               | 724 Transportation        |  |
| 395 Infertility Diagnosis or Treatment        |                           |  |
| 997 Office Visit/Consult                      |                           |  |
| 794 Outpatient Services                       |                           |  |
| 171 Outpatient Surgery                        |                           |  |

\*\* 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.**

**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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