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

absolute total care | Healthy Connections

OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

☐ 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

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
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)

**** 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.