OUTPATIENT MEDICAID
PRIOR AUTHORIZATION/REFERRAL FAX FORM

Complete and Fax to: 1-866-209-3703

CountyCare HEALTH PLAN

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

☐ Standard Request - Determination within 10 calendar days from receipt of all necessary information.

☐ Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 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

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

ICD-9 ☐ ICD-10 ☐

Primary Procedure Code * (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-9/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)* ☐☐☐

422	Biopharmacy	799	Genetic Counseling	171	Outpatient Surgery
292	Cardiac Rehab	709	Genetic Testing	912	Oxygen Equipment/Gas Supply
924	Chiropractic	249	Home Health	202	Pain Management
712	Cochlear Implants and Surgery	729	Neuropsych Testing	101	Physical Therapy
		211	OB Ultrasound(s)	147	Prosthetics
	DME	790	Occupational Therapy	420	Pulmonary Rehab
417	Rental	497	Office Visit/Specialty Consult	650	Radiation Therapy
120	Purchase $ (Purchase Price)	210	Orthotics	701	Speech Therapy
		927	Outpatient Hospice	724	Transportation
299	Drug Testing	794	Outpatient Services		

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.