



OUTPATIENT MEDICAID

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

PRIOR AUTHORIZATION/REFERRAL FAX FORM

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.

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 <input type="text"/> (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.

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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