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Outpatient Authorization Supplemental Form

This page is optional and meant to be used when an authorization request exceeds more than four (4) Procedure Codes. When applicable, please submit this form with the Outpatient Prior Authorization Form to the applicable fax number.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

* Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

AUTHORIZATION REQUEST

*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
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Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days

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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