OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 1-855-537-3447
Behavioral Health Requests/Medical Records:844-307-4442
Transplant Request **Fax** to: 833-589-1240

☐ Request for additional units. Existing Authorization ____ Units ____

○ **Non-Urgent Request**

○ **Urgent Request -** For life-threatening condition, hospitalized member, treatment after stabilizing an emergency condition. Reason for urgency must be indicated to process as urgent.

Required Field for URGENT REQUESTS: Reason for urgency must be indicated to process as urgent

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Medicaid/Member ID

Last Name, First Name

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider (Please include servicing provider address if servicing provider is the same as requesting provider.)

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

*Servicing Provider Address

*City

*State

*Zip

AUTHORIZATION REQUEST

*Primary Diagnosis Code (ICD-10)

Place of Service Codes Full List: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

***Primary** Procedure Code (CPT/HCPCS)	(Modifier)	***Start Date OR** Admission Date (MMDDYYYY)	**End Date OR** Discharge Date (MMDDYYYY)	Total Units/Visits/Days	*Place Of Service Code
Additional Procedure Code (CPT/HCPCS)	(Modifier)	**Start Date OR** Admission Date (MMDDYYYY)	**End Date OR** Discharge Date (MMDDYYYY)	Total Units/Visits/Days	Place Of Service Code
Additional Procedure Code (CPT/HCPCS)	(Modifier)	**Start Date OR** Admission Date (MMDDYYYY)	**End Date OR** Discharge Date (MMDDYYYY)	Total Units/Visits/Days	Place Of Service Code
Additional Procedure Code (CPT/HCPCS)	(Modifier)	**Start Date OR** Admission Date (MMDDYYYY)	**End Date OR** Discharge Date (MMDDYYYY)	Total Units/Visits/Days	Place Of Service Code

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.