

# OUTPATIENT AUTHORIZATION FORM

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**

\*Medicaid/Member ID  Last Name, First Name  \*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 (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 <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	*Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	*Place Of Service Code <input type="text"/>
Additional Procedure Code <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	Place Of Service Code <input type="text"/>
Additional Procedure Code <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	Place Of Service Code <input type="text"/>
Additional Procedure Code <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	Place Of Service Code <input type="text"/>

**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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