ambetter. FROM superior healthplan

OUTPATIENT AUTHORIZATION FORM

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

☐ Request for additional units. Existing Authorization _____ Units _____

☐ **Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 3 calendar days to avoid complications and unnecessary suffering or severe pain.

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

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Member ID

*Date of Birth (MMDDYYYY)

Last Name, First

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

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

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Start Date OR** Admission Date (MMDDYYYY)

*Diagnosis Code (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 _____

☐ Check Box for Inpatient Elective Service

422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
410 Observation
997 Office Visit/Consult

794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Study
724 Transportation
993 Transplant Evaluation
209 Transplant Surgery

Behavioral Health
510 BH Medical Management
530 BH PHP
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
518 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME
417 Rental
120 Purchase _____ (Purchase Price)

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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