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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