

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>

AUTHORIZATION REQUEST

*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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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