



OUTPATIENT AUTHORIZATION FORM

Complete and Fax to: 1-844-474-7115

Request for additional units. Existing Authorization Units

Standard requests - Determination within 15 calendar days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

* INDICATES REQUIRED FIELD

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*Date of Birth

MEMBER INFORMATION

*Medicaid/Member ID

Last Name, First

(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

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

*Primary Procedure Code

Additional Procedure Code

*Start Date OR Admission Date

*Diagnosis Code

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

Additional Procedure Code

Additional Procedure Code

End Date OR Discharge Date

Total Units/Visits/Days

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

- | | | |
|---|-----------------------------------|-------------------------------------|
| 422 Biopharmacy | 410 Observation | |
| 712 Cochlear Implants & Surgery | 997 Office Visit/Consult | |
| 299 Drug Testing | 210 Orthotics | |
| 922 Experimental and Investigational Services | 794 Outpatient Services | |
| 709 Genetic Testing | 171 Outpatient Surgery | 417 DME - Rental |
| 249 Home Health | 202 Pain Management | 120 DME - Purchase (Purchase Price) |
| 390 Hospice Services | 147 Prosthetics | |
| 290 Hyperbaric Oxygen Therapy | 201 Sleep Study | |
| 211 OB Ultrasound | 750 Transport Fixed Wing Airplane | |
| | 792 Vendor | |

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 benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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