coordinated care

OUTPATIENT MEDICAID AUTHORIZATION FORM

Complete and **Fax** to:
Medical 877-212-6669
Behavioral 833-286-1086
Transplant 833-552-0998

☐ Request for additional units. Existing Authorization _____ Units _____

☐ **Standard requests -** Determination within 5 working days of receiving all necessary information, not to exceed 14 calendar days from receipt.

☐ **Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

***Physician Signature** _____

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Medicaid/Member ID

Last Name, First

ORDERING PROVIDER INFORMATION

*Ordering NPI

*Ordering TIN

Ordering Provider Contact Name

Ordering 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 boxes) ☐☐☐

299 Drug Testing
709 Genetic Testing
249 Home Health
390 Hospice Inpatient & Outpatient
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
201 Sleep Study
202 Pain Management
290 Hyperbaric Oxygen Therapy
112 Nutritional Supplements

790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
712 Cochlear Implants & Surgery
472 Stereotactic Radiosurgery

DME/Prosthetics/Orthotics

120 Purchase
417 Rental ☐ (Purchase Price)

Behavioral Health - please send all supporting forms and medical records as necessary based on service

512 Community Based Services - circle appropriate option:
ABA Services TMS
514 Day Treatment - Partial Hospitalization Program
515 Electroconvulsive Therapy
516 Intensive Outpatient Therapy
519 Outpatient Therapy
522 Psychiatric Evaluation

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.

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