coordinated care

OUTPATIENT MEDICAID

PRIOR AUTHORIZATION/REFERRAL FAX FORM

Complete and Fax to: (877) 212-6669

☐ Request for additional units. Existing Authorization Units

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

☐ Urgent Request - 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.

X

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

***** INDICATES REQUIRED FIELD*

MEMBER INFORMATION

Date of Birth * (MMDDYYYY)

Member ID/Medicaid ID *

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 boxes)*

422 Biopharmacy

712 Cochlear Implants & Surgery

DME

417 Rental

120 Purchase $ (Purchase Price)

299 Drug Testing

709 Genetic Testing

249 Home Health

211 OB Ultrasound(s)

410 Observation

497 Office Visit/Specialty Consult

210 Orthotics

927 Outpatient Hospice

794 Outpatient Services

171 Outpatient Surgery

202 Pain Management

147 Prosthetics

472 Stereotactic Radiosurgery

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.

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