ambetter. FROM pa health & wellness.

OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 1-833-893-1482

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ **Standard requests -** Determination within 2 business 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.

URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Medicaid/Member ID

*Date of Birth (MMDDYYYY)

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
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation

DME
417 Rental
120 Purchase (Purchase Price)

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.

Rev. 10.29.2024

EP-PAF-5867

For Ambetter Outpatient Drug/Buy & Bill Requests:

☐ Check for urgent requests Please FAX this completed form to: 1-833-893-1482

PA requests with missing/incomplete required fields may be denied due to lack of information. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.

I. Member Information:	**II. Prescriber Information:**
Name:	Name:
ID Number:	Specialty:
Gender:	NPI or DEA Number:
Date of Birth:	Phone:
Medication Allergies:	Fax:
Member's Height:	Prior Auth Contact Name:
Member's Weight (kg.):	Prior Auth Contact Phone:
III. Diagnosis (as relevant to this request):	
Diagnosis:	ICD10:
Date of Diagnosis:	NOTE: Include diagnostic clinicals (labs, radiology, etc.)
IV. Drug Information (only ONE drug per form):	
HCPCS code:	Medication Name:
Strength:	Dosage Form/Administration route:
Start Date:	Directions for Use (sig):
End Date:	Total Number of Visits requested:
V. Medication History for Diagnosis:	
A. Is the member currently treated on this medication? [ ] Yes. How long? _____ [go to item B]	[ ] No [skip items B & C; go to item D]
B. Is this request for continuation of a previous approval from Pennsylvania Health & Wellness? [ ] Yes [go to item C]	[ ] No [skip item C; go to item D]
C. Has strength, dosage form, quantity, or frequency increased or decreased? [ ] Yes. New directions: _____	[ ] No
D. Please indicate previous treatment and outcomes below (previous medications tried and failed & non-pharm treatment)	

Drug Name or Therapy/Directions (sig)	Dates of Therapy (start and end dates)	Reason for Discontinuation
1)		
2)		
3)		
4)		
5)		

VI. Rationale for Request and Pertinent Clinical Information:

NOTE: Supporting documentation (such as office chart notes, lab results, prior therapy and other clinical information) is REQUIRED for consideration of approval.

Prescriber Signature:	Date:

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 PA Health & Wellness policy and procedures.