



OUTPATIENT AUTHORIZATION FORM

Buy & Bill Drugs 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

Last Name, First

*Date of Birth

(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

(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)

709 Genetic Testing- For Genetic Testing please include GTU:

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

For Ambetter Outpatient Biopharmacy/Buy and 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?			
<input type="checkbox"/> Yes. How long? _____ [go to item B] <input type="checkbox"/> No [skip items B & C; go to item D]			
B. Is this request for continuation of a previous approval from Pennsylvania Health & Wellness?			
<input type="checkbox"/> Yes [go to item C] <input type="checkbox"/> No [skip item C; go to item D]			
C. Has strength, dosage form, quantity, or frequency increased or decreased?			
<input type="checkbox"/> Yes. New directions: _____ <input type="checkbox"/> 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:	