



# OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 1-844-827-4948  
Transplant **Fax** to: 1-833-590-1583

☐ 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)

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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