ambetter. FROM pa health & wellness.

OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to:
1-844-827-4948

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

☐ **Standard requests -** Determination within 14 calendar days of receipt of request.

☐ **Expedited 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.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth ☐☐☐☐☐☐☐☐ (MMDDYYYY)

*Medicaid/Member 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) ☐☐☐

199 Adult Day Care
412 Auditory Services
422 Biopharmacy
712 Cochlear Implants & Surgery
682 Community Transition Waiver Services
299 Drug Testing
725 Emergency Response-Installation
340 Emergency Response-Monthly Rental
597 Employment Assistance/Support Services
922 Experimental/Investigational Services
205 Genetic Testing & Counseling
755 Habilitation
249 Home Health
657 Home Health Waiver
225 Home Meals
104 Home Modifications
390 Hospice Services
290 Hyperbaric Oxygen Therapy
307 Member Training
112 Nutritional Supplements and/or Services
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
470 Personal Care Worker
827 Pest Control
421 Respite Services
201 Sleep Study
472 Sterotactic Radiosurgery
975 Telemedicine
724 Transport

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.

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.

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