MEDICARE OUTPATIENT AUTHORIZATION

PENNSYLVANIA

All Part B Drug Requests: **Fax** 844-941-1330
Non Duals Expedited Requests: **Call** 1-800-977-7522
Duals Expedited Requests: **Call** 1-844-796-6811
Standard Requests: **Fax** 1-844-259-4568
Transplant Requests: **Fax** 1-833-590-1585
Behavioral Requests: **Fax** 1-833-325-1772

☐ Request for additional units. Existing Authorization _____ Units _____

For Standard (Elective Admission) requests, complete this form and FAX to the appropriate department above. Determination made as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days after receipt of request.

☐ **For Non Duals Expedited requests, Please Call1-800-977-7522. For Duals, Call 1-844-796-6811**. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

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) _____

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult
422 Biopharmacy (Please fax to 844-941-1330)
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Studies
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
212 Therapy Evaluation
993 Transplant Evaluation
724 Transportation
209 Transplant Surgery

Behavioral Health
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
510 BH Medical Management
516 BH Intensive Outpatient Therapy (IOP)
518 BH Mental Health /Chemical - Dependency Observation
519 BH Outpatient Therapy
530 BH Partial Hospitalization Program (PHP)
520 BH Professional Fees
522 BH Psychiatric Evaluation

DME
417 DME - Rental
120 DME - Purchase
Purchase Price

Are services needed for discharge planning? ☐ **YES** ☐ **NO**

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.

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For Medicare Outpatient Biopharmacy/Buy and Bill Requests:

☐ Check for urgent requests Please FAX this completed form to: 1-844-941-1330

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.