pa health & wellness

OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Buy & Bill Requests **Fax** to: 1-833-541-2294
Transplant Requests **Fax** to: 1-833-590-1584
All Others **Fax** to: 1-844-307-0997

☐ 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

*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) _____

412 Auditory Services
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental/Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
112 Nutritional Supplements and/or Services
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
724 Transport
202 Pain Management
201 Sleep Study
472 Stereotactic Radiosurgery
212 Therapy Evaluation
101 Physical Therapy
790 Occupational Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
975 Telemedicine

DME

417 Rental
120 Purchase (Purchase Price)

Drugs

422 Outpatient Drugs - Biopharmacy
(Fax Buy & Bill Drug Requests to **1-833-541-2294**)

Waiver Only Services

199 Adult Day Care
682 Community Transition Waiver Services
725 Emergency Response-Installation
340 Emergency Response-Monthly Rental
597 Employment Assistance/Support Services
755 Habilitation
657 Home Health Waiver
225 Home Meals
104 Home Modifications
307 Member Training
470 Personal Care Worker
827 Pest Control
421 Respite Services

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 Medicaid Outpatient Drug/Buy & Bill Requests:

☐ Check for urgent requests Please FAX this completed form to: 1-833-541-2294

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.