

OUTPATIENT MEDICAID AUTHORIZATION FORM

Complete and Fax to:
Medical: 1-888-453-4316
Behavioral: 1-844-824-7705
Transplant: 1-833-590-1588

☐ Request for additional units. Existing Authorization Units

☐ **Standard requests** - Determination within 14 calendar days of receiving all necessary information.

☐ **Urgent requests** - I certify this request is urgent to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 72 hours.

X

**URGENT REQUESTS MUST BE SIGNED BY THE
REQUESTING 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

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
141 Imaging
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management

(Enter the Service type number in the boxes)

101 Physical Therapy
701 Speech Therapy
790 Occupational Therapy
209 Transplant Surgery
992 Transplant Evaluation
724 Transportation

DME

417 Rental
120 Purchase

(Purchase Price)

**If you are requesting Biopharmacy, please use the
Biopharmacy Prior Authorization Form on the website.**

For high tech imaging, please continue to contact NIA.

Behavioral Health

510 Medical Management
530 Partial Hospital Program
512 Community Based Services
513 Crisis Psychotherapy
514 Day Treatment
515 Electroconvulsive Therapy
516 Intensive Outpatient Therapy
518 Mental Health/Chemical
Dependency Observation
519 Outpatient Therapy
520 Professional Fees
521 Psychological Testing
522 Psychiatric Evaluation

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.

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