MEDICARE OUTPATIENT AUTHORIZATION

KANSAS

All Part B Drug Requests **Fax:** 1-844-943-1508
Expedited Requests Non Duals **Call:** 1-800-977-7522
Expedited Requests Duals **Call:** 1-844-796-6811
Standard Requests **Fax**: 1-844-885-3724
Transplant Requests **Fax:** 1-833-590-1589

☐ 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 Expedited requests, Non Duals, please CALL 1-800-977-7522 and 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

*** 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 844-943-1508)

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

709 Genetic Testing- For Genetic Testing please include GTU: _____

Behavioral Health

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

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.