



OUTPATIENT MEDICAID PRIOR AUTHORIZATION FAX FORM

Complete and Fax to:
(888) 453-4316

Request for additional units. Existing Authorization Units

Standard Request - Determination within 14 calendar days of receiving all necessary information

Urgent Request - 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.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID * Last Name, First * Date of Birth *
(MDDYYYY)

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 * Additional Procedure Code Start Date OR Admission Date * Diagnosis Code *
(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MDDYYYYY) (ICD-10)

Additional Procedure Code Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days * Additional Diagnosis Code
(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MDDYYYYY) (ICD-10)

OUTPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

712 Cochlear Implants & Surgery	497 Office Visit/Specialty Consult
911 Dental Anesthesia - Office Visit	210 Orthotics \$ <input type="text"/>
DME	927 Outpatient Hospice
417 Rental	794 Outpatient Services
120 Purchase \$ <input type="text"/>	411 Surgical Procedures
(Purchase Price)	202 Pain Management
299 Drug Testing	147 Prosthetics \$ <input type="text"/>
709 Genetic Testing	760 Air Ambulance
249 Home Health	771 Dialysis
211 OB Ultrasound(s)	912 Oxygen Equipment/Gas Supply

If you are requesting Biopharmacy, please use the Biopharmacy Prior Authorization Form on the website.
For high tech imaging, please continue to contact NIA.

**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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