

OUTPATIENT AUTHORIZATION FORM

Standard Requests:	Fax 844-275-1405
ransplant Requests	· Fax 833-414-1389

Bill & Buy Drugs: 833-893-1488

Request for additional units. Existing	g Authorization	Units		
Standard requests - Determination wit	chin 15 calendar days of receiving all necessar	ry information.		
I certify this request	t is urgent and medically necessary to treat a plications and unnecessary suffering or seve	an injury, illness or condition (not life threate	ning) within 72	
* INDICATES REQUIRED FIELD	X	URGENT REQUESTS MUST BE SIG REQUESTING PHYSICIAN TO RECI	EIVE DDIODITY	
		*Date of Birth		
MEMBER INFORMATION				
*Member ID	Last Name, Firs	(MMDDYYYY)		
REQUESTING PROVIDER INFORMA	ATION			
*Requesting NPI	*Requesting TIN	Requesting Provider Contact Name	,	
Requesting Provider Name	Phone	*Fax		

Same as Requesting Provider	INFORMATION			
and as negassang review	*Compinion TIN	Complete Provides Contact North		
*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	
			2.ng.100.0 0000	
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(ICD-10)	
Additional Procedure Code	Additional Procedure Code	End Date OR Discharge Date	Total Units/Visits/Days	
Additional Frocedure Code	Additional Flocedure Code	Life Date On Discharge Date	Total Offics, visits, Days	
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)		
*OUTPATIENT SERVICE TYPE	,	par in the hoves		
412 Auditory	(Enter the Service type numb	· hankani		
412 Additiony 422 Biopharmacy	997 Office Visit/Consult 794 Outpatient Services	Behavioral Health 533 BH ABA Services		
712 Cochlear Implants & Surgery	171 Outpatient Surgery	510 BH Medical Management		
299 Drug Testing 922 Experimental and Investigational Se	202 Pain Management rvices 650 Radiation Therapy	530 BH PHP 512 BH Community Based Services		
205 Genetic Testing & Counseling	201 Sleep Study	512 BH Community Based Services 514 BH Day Treatment		
249 Home health	993 Transplant Evaluation	515 BH Electroconvulsive Therapy		
390 Hospice Services 290 Hyperbaric Oxygen Therapy	209 Transplant Surgery	516 BH Intensive Outpatient Therapy		
141 Imaging	724 Transportation	518 BH Mental Health /Chemical Dependency Observation 519 BH Outpatient Therapy		
395 Infertility Diagnosis or Treatment	DME 417 Rental	520 BH Professional Fees		
410 Observation	120 Purchase (Purchase Price)	521 BH Psychological Testing		
211 OB Ultrasound	(ruitildse riite)	522 BH Psychiatric Evaluation	nn .	
		322 Bill Sychiatile Evaluation	/ ¹¹	

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 benefit and medically necessary with prior authorization as per

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