MEDICAID

PRIOR AUTHORIZATION/REFERRAL FAX FORM

Complete and Fax to: (866) 467-1316

☐ Request for additional units. Existing Authorization ______ Units ______

☐ Standard Request - Determination within 5 working days of receiving all necessary information, not to exceed 14 calendar days from receipt.

☐ Urgent Request - 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.

X ______

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

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member Phone Number

Date of Birth *

(MMDDYYYY)

Member ID/Medicaid ID *

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)

422	Biopharmacy
401	Cardiac Pulmonary Rehab
771	Dialysis
	DME
417	Rental
120	Purchase — $ ______ (Purchase Price)
299	Drug Testing
709	Genetic Testing
249	Home Health
141	Imaging Services
211	OB Ultrasound(s)
790	Occupational Therapy
497	Office Visit/Specialty Consult
927	Outpatient Hospice
794	Outpatient Services
	Pain Management
429	Office Visit
170	Other Site
470	Personal Care Worker Services
101	Physical Therapy
325	Podiatry Office Visit
201	Sleep Study
701	Speech Therapy
	Surgery
400	Inpatient
427	Outpatient
724	Transportation

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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For Medicare Prior Authorization Requests-Please fax to 877-687-1183.

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