



OUTPATIENT MEDICAID PRIOR AUTHORIZATION FAX FORM

Complete and Fax to:
SN/Rehab/LTAC (all requests)
1-866-529-0291

Home Health Care
and Hospice (all requests)
1-855-339-5145

DME All DME/Sleep Study/Quantitative
Drug Tests/Genetic Testing Requests-
1-866-535-4083

PA requests (all other PA requests)
1-866-529-0290

Request for additional units. Existing Authorization Units

Standard Request

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.

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 * (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)

422 Biopharmacy
401 Cardiac Pulmonary Rehab

790 Occupational Therapy
497 Office Visit/Specialty Consult
927 Outpatient Hospice

201 Sleep Study
701 Speech Therapy
724 Transportation

DME (Orthotics and Prosthetics)

711 Rental
700 Purchase (Purchase Price)

794 Outpatient Services
171 Outpatient Surgery

Pain Management

299 Drug Testing
709 Genetic Testing
249 Home Health
211 OB Ultrasound(s)

429 Office Visit
170 Other Site

101 Physical Therapy

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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