buckeye health plan | MyCareOhio Connecting Medicare + Medicaid

MEDICARE-MEDICAID PLAN (MMP) OUTPATIENT AUTHORIZATION

All Part B Drug Requests: **Fax** 1-844-941-1329
Expedited Requests: **Call** 1-866-389-7690
Standard Requests: **Fax** 1-877-861-6722
Transplant Requests: **Fax** 1-833-974-3116

☐ Request for additional units. Existing Authorization _____ Units _____

For All Standard or Expedited Part B Drug Requests please FAX to 1-844-941-1329.

For Standard requests, complete this form and FAX to 1-877-861-6722. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.

For Expedited requests, please CALL 1-866-389-7690 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 serious jeopardy.

*** 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

If this request is for a Part B DRUG, please fax to 1-844-941-1329.

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) _____

401 Cardiac/Pulmonary Rehab
712 Cochlear Implants & Surgery
660 Hearing Aide
299 Drug Testing
922 Experimental & Investigationsal Services
205 Genetic Testing & Counseling
249 Home Health
927 Hospice Outpatient
290 Hyperbaric Oxygen Therapy
729 Neuropsychological Testing

422 Biopharmacy (please fax to 1-844-941-1329)
724 Transportation
112 Nutritional Supplements and/or Services
211 OB Ultrasound
410 Observation
997 Office Visit/Consult
419 Transplant Work Up
209 Transplant Surgery

794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
427 Rehab
201 Sleep Study
212 Therapy Evaluation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy

DME (Orthotics and Prosthetics)

711 Rental
700 Purchase _____ (Purchase Price)

<u>Outpatient Services Example</u>:
-Skin Debridement/wound care

<u>Home Health Example</u>:
-Skilled Nursing Visits

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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