ambetter. FROM coordinated care.

OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to:
Medical 855-218-0592
Behavioral 833-286-1086
Transplant 833-552-1001

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐

☐ **Standard requests -** Determination within 5 calendar days of receiving all necessary information.

☐ **Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

*** INDICATES REQUIRED FIELD** X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

MEMBER INFORMATION

*Date of Birth ☐☐☐☐☐☐☐☐ (MMDDYYYY)

*Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name, First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ORDERING PROVIDER INFORMATION

*Ordering NPI ☐☐☐☐☐☐☐☐☐☐

*Ordering TIN ☐☐☐☐☐☐☐☐☐

Ordering Provider Contact Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Ordering Provider Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Phone ☐☐☐☐☐☐☐☐☐☐

*Fax ☐☐☐☐☐☐☐☐☐☐

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ Same as Ordering 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) ☐☐☐

412 Auditory
712 Cochlear Implants & Surgery
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
997 Office Visit/Consult
794 Outpatient Services
299 Drug Testing

202 Pain Management
171 Outpatient Surgery
650 Radiation Therapy
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

DME
417 Rental
120 Purchase ☐☐☐☐☐ (Purchase Price)

Behavioral Health-please send all supporting forms and medical records as necessary based on service
515 Electroconvulsive Therapy
516 Intensive Outpatient Therapy
518 Mental Health /Chemical Dependency Observation
521 Psychological Testing
512 Community Based Services - circle appropriate option: ABA Services TMS
510 Medical Management
519 Outpatient Therapy
522 Psychiatric Evaluation
514 Day Treatment - Partial Hospitalization Program

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.

Rev. 09 03 2020
EW-PAF-0687