

# OUTPATIENT AUTHORIZATION FORM

Request for additional units. Existing Authorization  Units

**Standard requests** - Determination within 2 business 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 72 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

**\* INDICATES REQUIRED FIELD**

**MEMBER INFORMATION**

\*Medicaid/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**

\*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                               | 794 Outpatient Services   | <b>Behavioral Health</b>                              |
| 712 Cochlear Implants & Surgery               | 171 Outpatient Surgery    | 512 BH Community Based Services                       |
| 299 Drug Testing                              | 202 Pain Management       | 515 BH Electroconvulsive Therapy                      |
| 922 Experimental and Investigational Services | 650 Radiation Therapy     | 516 BH Intensive Outpatient Therapy                   |
| 205 Genetic Testing & Counseling              | 201 Sleep Study           | 518 BH Mental Health /Chemical Dependency Observation |
| 249 Home Health                               | 993 Transplant Evaluation | 519 BH Outpatient Therapy                             |
| 390 Hospice Services                          | 209 Transplant Surgery    | 520 BH Professional Fees                              |
| 290 Hyperbaric Oxygen Therapy                 | 724 Transportation        | 522 BH Psychiatric Evaluation                         |

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

**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.

## For Ambetter Outpatient Drug/Buy & Bill Requests:

Check for urgent requests

Please FAX this completed form to: 1-833-893-1482

*PA requests with missing/incomplete required fields may be denied due to lack of information. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.*

|  |  |  |  |
|--|--|--|--|
| <b>I. Member Information:</b>  |  | <b>II. Prescriber Information:</b>                         |  |
| Name:  |  | Name:  |  |
| ID Number:   |  | Specialty:   |  |
| Gender:  |  | NPI or DEA Number:   |  |
| Date of Birth:   |  | Phone:   |  |
| Medication Allergies:  |  | Fax:   |  |
| Member's Height:   |  | Prior Auth Contact Name:                                   |  |
| Member's Weight (kg.):   |  | Prior Auth Contact Phone:                                  |  |
| <b>III. Diagnosis (as relevant to this request):</b>   |  |  |  |
| Diagnosis:   |  | ICD10:   |  |
| Date of Diagnosis:   |  | NOTE: Include diagnostic clinicals (labs, radiology, etc.) |  |
| <b>IV. Drug Information (only ONE drug per form):</b>  |  |  |  |
| HCPCS code:  |  | Medication Name:   |  |
| Strength:  |  | Dosage Form/Administration route:                          |  |
| Start Date:  |  | Directions for Use (sig):                                  |  |
| End Date:  |  | Total Number of Visits requested:                          |  |
| <b>V. Medication History for Diagnosis:</b>  |  |  |  |
| A. Is the member currently treated on this medication?<br><input type="checkbox"/> Yes. How long? _____ [go to item B] <input type="checkbox"/> No [skip items B & C; go to item D]                    |  |  |  |
| B. Is this request for continuation of a previous approval from Pennsylvania Health & Wellness?<br><input type="checkbox"/> Yes [go to item C] <input type="checkbox"/> No [skip item C; go to item D] |  |  |  |
| C. Has strength, dosage form, quantity, or frequency increased or decreased?<br><input type="checkbox"/> Yes. New directions: _____ <input type="checkbox"/> No  |  |  |  |
| D. Please indicate previous treatment and outcomes below (previous medications tried and failed & non-pharm treatment)   |  |  |  |
| Drug Name or Therapy/Directions (sig)  | Dates of Therapy (start and end dates) | Reason for Discontinuation                                 |  |
| 1)   |  |  |  |
| 2)   |  |  |  |
| 3)   |  |  |  |
| 4)   |  |  |  |
| 5)   |  |  |  |
| <b>VI. Rationale for Request and Pertinent Clinical Information:</b>   |  |  |  |
| NOTE: Supporting documentation (such as office chart notes, lab results, prior therapy and other clinical information) is REQUIRED for consideration of approval.                                      |  |  |  |
|  |  |  |  |
| Prescriber Signature:  |  | Date:  |  |