OUTPATIENT AUTHORIZATION FORM

ambetter. FROM | **pa health & wellness**

☐ 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

*Date of Birth [＿＿＿＿＿＿＿＿] (MMDDYYYY)

*Medicaid/Member 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	794 Outpatient Services
712 Cochlear Implants & Surgery	171 Outpatient Surgery
299 Drug Testing	202 Pain Management
922 Experimental and Investigational Services	650 Radiation Therapy
205 Genetic Testing & Counseling	201 Sleep Study
249 Home Health	993 Transplant Evaluation
390 Hospice Services	209 Transplant Surgery
290 Hyperbaric Oxygen Therapy	724 Transportation

Behavioral Health
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation

DME
417 Rental
120 Purchase [＿＿＿＿＿＿] (Purchase Price)

709 Genetic Testing- For Genetic Testing please include GTU: [＿＿＿]

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.