



# BIOPHARMACY OUTPATIENT Prior Authorization Fax Form

Fax to:  
1-866-562-8989

Request for additional units. Existing Authorization  Units

Standard and Urgent Pre-Service Requests - Determination within 3 calendar days (72 hours) of receiving the request

**\* 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

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

MEDICATION REQUESTED			
Medication Name	Strength	Dose	Quantity
Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)*			

**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 benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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