OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 833-405-3828
Transplant Request **Fax** to: 833-828-0211
Buy & Bill Drugs **Fax** to: 844-235-5090
Behavioral Health Fax to: 833-522-2796

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

☐ **Standard requests -** Determination within 15 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 72 hours to avoid complications and unnecessary suffering or severe pain.

X ________________ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*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

*Servicing Provider Address

*City

*State

*Zip

AUTHORIZATION REQUEST

*Primary Diagnosis Code (ICD-10)

Place of Service Codes Full List: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

***Primary** Procedure Code 1	***Start Date OR** Admission Date 1	**End Date OR** Discharge Date 1	Total Units/Visits/Days 1	*Place Of Service Code 1
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

Additional Procedure Code 2	**Start Date OR** Admission Date 2	**End Date OR** Discharge Date 2	Total Units/Visits/Days 2	Place Of Service Code 2
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

Additional Procedure Code 3	**Start Date OR** Admission Date 3	**End Date OR** Discharge Date 3	Total Units/Visits/Days 3	Place Of Service Code 3
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

Additional Procedure Code 4	**Start Date OR** Admission Date 4	**End Date OR** Discharge Date 4	Total Units/Visits/Days 4	Place Of Service Code 4
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

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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