Outpatient Authorization Form

Complete and **Fax** to: 833-611-2514
Transplant Request **Fax** to: 833-611-2454
Behavioral Health Fax to: 833-615-0098

☐ 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

*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
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
211 OB Ultrasound
395 Infertility Diagnosis or Treatment
650 Radiation Therapy
210 Orthotics
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
729 Neuropsychological Testing

Behavioral Health
533 BH Applied Behavioral Analysis
512 BH Community Based Services
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

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.

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