

## OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 1-844-430-4485 Transplant Request **Fax** to: 1-833-769-1148 Behavioral Health **Fax** to: 1-877-941-0481

Standard requests - Determination within 14 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 2 business days to avoid complications and unnecessary suffering or severe pain.   INDICATES REQUESTING PROVIDED	Request for additional units. Existing	g Authorization		Units		
ness days to avoid complications and unnecessary suffering or severe pain.    URGENT REQUESTING PHYSICIAN TO RECEIVE PRIORITY.	Standard requests - Determination with	nin 14 calendar days of receiving all	necessary informa	ition.		
MEMBER INFORMATION  *Member ID Last Name, First (MISSING)  REQUESTING PROVIDER INFORMATION  *Requesting NPI	ness days to avoid complications and ι	s urgent and medically necessary to unnecessary suffering or severe pair	o treat an injury, il n.	URGENT REQUEST	TS MUST BE SIG	NED BY THE
**Member ID				*Date of E	Birth	
REQUESTING PROVIDER INFORMATION  *Requesting Provider Name  Phone  *Fax  *Fax  SERVICING PROVIDER / FACILITY INFORMATION  *Servicing Provider Name  Phone  *Servicing Provider Contact Name  *Servicing Provider Name  Phone  *Servicing Provider Contact Name  **Servicing Provider Co	MEMBER INFORMATION					
**Requesting NPI **Requesting TIN Requesting Provider Contact Name  **Phone **Fax  **SERVICING PROVIDER / FACILITY INFORMATION  **Servicing Provider Same as Requesting Provider  **Servicing NPI **Servicing TIN Servicing Provider Contact Name  **Servicing Provider/Facility Name Phone Fax  **AUTHORIZATION REQUEST  **Primary Procedure Code Additional Procedure Code **Start Date OR Admission Date **Diagnosis Code  **CPT/HCPCS (Modifier) CCPT/HCPCS (Modifier) Modifier) CCPT/HCPCS (Modifier) Total Units/Visits/Days  **CPT/HCPCS (Modifier) CCPT/HCPCS (Modifier) CCPT/HCPCS (Modifier) Total Units/Visits/Days	*Member ID	Last	Name, First	(MMDDYYYY)	)	
**Requesting NPI **Requesting TIN Requesting Provider Contact Name  **Phone **Fax  **SERVICING PROVIDER / FACILITY INFORMATION  **Servicing Provider Same as Requesting Provider  **Servicing NPI **Servicing TIN Servicing Provider Contact Name  **Servicing Provider/Facility Name Phone Fax  **AUTHORIZATION REQUEST  **Primary Procedure Code Additional Procedure Code **Start Date OR Admission Date **Diagnosis Code  **CPT/HCPCS (Modifier) CCPT/HCPCS (Modifier) Modifier) CCPT/HCPCS (Modifier) Total Units/Visits/Days  **CPT/HCPCS (Modifier) CCPT/HCPCS (Modifier) CCPT/HCPCS (Modifier) Total Units/Visits/Days						
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 Additional Procedure Code Start Date OR Admission Date Diagnosis Code  (CET/HICCES) (Modifier) (CET/HICCES) (Modifier) (MMDDTYY)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (Modifier) (MMDDTYY)	REQUESTING PROVIDER INFORMA	ATION				
SERVICING PROVIDER / FACILITY INFORMATION  Same as Requesting Provider  *Servicing NPI  *Servicing Provider/Facility Name  Phone  Fax  AUTHORIZATION REQUEST  *Primary Procedure Code  Additional Procedure Code  Additional Procedure Code  Additional Procedure Code  Additional Procedure Code  End Date OR Discharge Date  Total Units/Visits/Days  (CPT/HCPCS)  (Modifier)  (MMDDYYY)	*Requesting NPI	*Requesting TIN	F	equesting Provider Cor	ntact Name	
SERVICING PROVIDER / FACILITY INFORMATION  Same as Requesting Provider  *Servicing NPI  *Servicing Provider/Facility Name  Phone  Fax  AUTHORIZATION REQUEST  *Primary Procedure Code  Additional Procedure Code  Additional Procedure Code  Additional Procedure Code  Additional Procedure Code  End Date OR Discharge Date  Total Units/Visits/Days  (CPT/HCPCS)  (Modifier)  (MMDDYYY)						
Servicing NPI *Servicing TIN Servicing Provider Contact Name  *Servicing Provider/Facility Name Phone Fax  *AUTHORIZATION REQUEST  *Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY)	Requesting Provider Name	Phor	ne		*Fax	
Servicing NPI *Servicing TIN Servicing Provider Contact Name  *Servicing Provider/Facility Name Phone Fax  *AUTHORIZATION REQUEST  *Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY)						
Servicing NPI *Servicing TIN Servicing Provider Contact Name  *Servicing Provider/Facility Name Phone Fax  *AUTHORIZATION REQUEST  *Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY)	SERVICING PROVIDER / FACILITY	INFORMATION				
Servicing Provider/Facility Name Phone Fax  AUTHORIZATION REQUEST  *Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY) (CD-10)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYY)						
*Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)	*Servicing NPI	*Servicing TIN	S	ervicing Provider Conta	act Name	
*Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)						
*Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (MMDDYYYY)	Servicing Provider/Facility Name	Phone			Fax	
*Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code  (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (MMDDYYYY)						
(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)  Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (MMDDYYYY)	AUTHORIZATION REQUEST					
(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)					e	<u> </u>
( Common ( C	Additional Procedure Code	Additional Procedure Code	End Dat	e OR Discharge Date		Total Units/Visits/Days
( Common ( C	(CDT/HCDCS) (Marifice)	(CDT/HCDCS) (Macifica)	(MMDDYYY	Y)		
	, ,					
Behavioral Health DME					DME	
412 Auditory 410 Observation 533 BH Applied Behavioral Analysis 417 Rental	<ul> <li>422 Biopharmacy</li> <li>712 Cochlear Implants &amp; Surgery</li> <li>299 Drug Testing</li> <li>922 Experimental and Investigational Services</li> <li>205 Genetic Testing &amp; Counseling</li> <li>249 Home Health</li> <li>390 Hospice Services</li> <li>290 Hyperbaric Oxygen Therapy</li> </ul>	410 Observation 597 Office Visit/Consult 210 Orthotics 5794 Outpatient Services 171 Outpatient Surgery 202 Pain Management 147 Prosthetics 501 Sleep Study 993 Transplant Evaluation 209 Transplant Surgery 55	533 BH Applied Be 512 BH Community 515 BH Electrocon 516 BH Intensive O 510 BH Medical Ma 518 BH Mental Hea 519 BH Outpatient 530 BH PHP 520 BH Professiona 522 BH Psychiatric	havioral Analysis Based Services Julsive Therapy utpatient Therapy anagement alth /Chemical Deper Therapy al Fees Evaluation	417 Rental 120 Purchase	, ,

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

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.