

# OUTPATIENT MEDICARE AUTHORIZATION FORM

Complete and Fax to: (877) 861-6722

☐ Request for additional units. Existing Authorization  Units

☐ Standard Request - Determination within 14 days from receipt of all necessary information.

☐ Expedited Request - 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 REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

\* INDICATES REQUIRED FIELD

## MEMBER INFORMATION

Member ID \*  Last Name, First  Date of Birth \*

## 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

<b>Primary Procedure Code *</b> <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	<b>Additional Procedure Code</b> <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	<b>Start Date OR Admission Date *</b> <input type="text"/> (MMDDYYYY)	<b>Diagnosis Code *</b> <input type="text"/> <input type="text"/> (ICD-10)
<b>Additional Procedure Code</b> <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	<b>Additional Procedure Code</b> <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	<b>End Date OR Discharge Date</b> <input type="text"/> (MMDDYYYY)	<b>Total Units/Visits/Days</b> <input type="text"/>

### OUTPATIENT SERVICE TYPE\*

(Enter the Service type number in the boxes)

422 Biopharmacy	794 Outpatient Services	617 Non-Emergent Medical
	171 Outpatient Surgery	Transportation-Ambulance Only
<b>DME (Orthotics and Prosthetics)</b>	997 Office Visit/Consult (non par only)	290 Hyperbaric Oxygen Therapy
417 Rental	202 Pain Management	
120 Purchase <input type="text"/>	420 Pulmonary Rehab	
(Purchase Price)	201 Sleep Study	
299 Drug Testing		
709 Genetic Testing	<b>Therapy</b>	
249 Home Health	790 Occupational	
729 Neuropsych Testing	101 Physical	
410 Observation (only > 48 hrs)	701 Speech	

**Outpatient Services Example:**  
- Skin Debridement/Wound Care

**Home Health Examples:**  
- Skilled Nursing Visits  
- Home Health Aid

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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