coordinated care

OUTPATIENT MEDICAID

Complete and Fax to: (877) 212-6669

PRIOR AUTHORIZATION/REFERRAL FAX FORM

☐ Request for additional units. Existing Authorization _____ Units _____

☐ Standard Request - Determination within 5 working days of receiving all necessary information, not to exceed 14 calendar days from receipt.

☐ Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 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/Medicaid 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* 1104893766

Servicing TIN* 911134800

Servicing Provider Contact Name MICHELE BAILEY

Servicing Provider/Facility Name DIAGNOSTICCYTO

Phone 2063282026

Fax 2063252975

AUTHORIZATION REQUEST

ICD-9 ■ ICD-10 ☐

Primary Procedure Code* 88235 (CPT/HCPCS) (Modifier)

Additional Procedure Code 88285 (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date* (MMDDYYYY)

Diagnosis Code* (ICD-9/ICD-10)

Additional Procedure Code 88280 (CPT/HCPCS) (Modifier)

Additional Procedure Code 88291 (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Total Units/Visits/Days

OUTPATIENT SERVICE TYPE* ***(Enter the Service type number in the boxes)*** 709

422	Biopharmacy	211	OB Ultrasound(s)
712	Cochlear Implants & Surgery	410	Observation
		497	Office Visit/Specialty Consult
	DME	210	Orthotics
417	Rental	927	Outpatient Hospice
120	Purchase $ (Purchase Price)	794	Outpatient Services
		171	Outpatient Surgery
299	Drug Testing	202	Pain Management
709	Genetic Testing	147	Prosthetics
249	Home Health	472	Stereotactic Radiosurgery

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.

Coordinated Care
Outpatient Prior Authorization
Additional CPT Codes Requested

Patient Name:_____

Date of Birth:_____

Additional Cytogenetics Codes

88267 or 88269

FISH Testing Codes

88377

Some codes may be excluded or charged in multiple units, depending on patient-specific testing parameters.