

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.

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 *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

ICD-9 ICD-10

Primary Procedure Code *

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Start Date OR Admission Date *

(MMDDYYYY)

Diagnosis Code *

(ICD-9/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 | 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 <input type="text"/> | 794 Outpatient Services |
| (Purchase Price) | 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.

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the 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.

Patient Name: _____

Date of Birth: _____

Additional Cytogenetics Codes

88289

FISH Testing Codes

88377

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