



# OUTPATIENT Prior Authorization Fax Form

Fax to: 855-685-6508

Request for additional units. Existing Authorization  Units

Standard Request - Determination within 15 calendar days of receiving all necessary information

Urgent 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

(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	<b>DME</b>	211 OB Ultrasound(s)	201 Sleep Study
924 Chiropractic	417 Rental	410 Observation	724 Transportation
712 Cochlear Implants and Surgery	120 Purchase <input type="text"/>	497 Office Visit/Specialty Consult	
	(Purchase Price)	210 Orthotics	
<b>Dental Anesthesia</b>	709 Genetic Testing	927 Outpatient Hospice	
911 Office Visit	249 Home Health	794 Outpatient Services	
721 Other Site	600 Home Infusion	171 Outpatient Surgery	
	290 Hyperbaric Oxygen Therapy	202 Pain Management	
771 Dialysis	611 Infertility Treatments	147 Prosthetics	
299 Drug Testing	240 Inpatient Hospice		

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 benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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