absolute total care | Healthy Connections

OUTPATIENT MEDICAID
PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 1-866-912-3606

☐ Request for additional units. Existing Authorization Units

☐ Standard Request - Determination within 14 calendar days of receiving request

☐ Urgent request – Determination within 72 hours of receiving request

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 *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

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

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (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)

412	Auditory Services	709	Genetic Testing	101	Physical Therapy
401	Cardiac Pulmonary Rehab	249	Home Health	201	Sleep Study
924	Chiropractic	410	Observation	701	Speech Therapy
712	Cochlear Implants & Surgery	790	Occupational Therapy	724	Transportation
	DME	497	Office Visit/Specialty Consult		
417	Rental $ (Purchase Price)	927	Outpatient Hospice		
120	Purchase	794	Outpatient Services		
		171	Outpatient Surgery		
299	Drug Testing	202	Pain Management		
922	Experimental and Investigational Procedure				

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.