

OUTPATIENT Prior Authorization Fax Form

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 24 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 *

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)

412 Auditory Services	771 Dialysis	290 Hyperbaric Oxygen Therapy	794 Outpatient Services
422 Biopharmacy	299 Drug Testing	611 Infertility Treatments	171 Outpatient Surgery
712 Cochlear Implants and Surgery	709 Genetic Testing	240 Inpatient Hospice	202 Pain Management
	249 Home Health	211 OB Ultrasound(s)	147 Prosthetics
Dental Anesthesia	600 Home Infusion	410 Observation	650 Radiation Therapy
911 Office Visit		497 Office Visit/Specialty Consult	201 Sleep Study
721 Other Site		210 Orthotics	724 Transportation
DME		927 Outpatient Hospice	
417 Rental			
120 Purchase			

\$
(Purchase Price)

**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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