ambetter. FROM magnolia health

OUTPATIENT
Prior Authorization Fax Form

Fax to: 855-300-2618

☐ 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
422 Biopharmacy
712 Cochlear Implants and Surgery

Dental Anesthesia
911 Office Visit
721 Other Site

DME
417 Rental
120 Purchase $ _____ (Purchase Price)

771 Dialysis
299 Drug Testing
709 Genetic Testing
249 Home Health
600 Home Infusion

290 Hyperbaric Oxygen Therapy
611 Infertility Treatments
240 Inpatient Hospice
211 OB Ultrasound(s)
410 Observation
497 Office Visit/Specialty Consult
210 Orthotics
927 Outpatient Hospice

794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
650 Radiation Therapy
201 Sleep Study
724 Transportation

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.