



FROM



OUTPATIENT Prior Authorization Fax Form

Fax to: 888-241-0664

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

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)

422 Biopharmacy

924 Chiropractic

712 Cochlear Implants and Surgery

Dental Anesthesia

911 Office Visit

721 Other Site

771 Dialysis

299 Drug Testing

DME

417 Rental

120 Purchase

\$
(Purchase Price)

709 Genetic Testing

249 Home Health

290 Hyperbaric Oxygen Therapy

611 Infertility Treatments

240 Inpatient Hospice

211 OB Ultrasound(s)

497 Office Visit/Specialty Consult

210 Orthotics

927 Outpatient Hospice

794 Outpatient Services

171 Outpatient Surgery

202 Pain Management

147 Prosthetics

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.

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996.

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