



OUTPATIENT MEDICARE AUTHORIZATION FORM

Standard Requests: Fax 1-877-808-9368
Part B Drug request: Fax to 1-844-960-1785
Behavioral Health Requests/Medical Records: Fax 1-855-772-7079

Request for additional units. Existing Authorization

Units

For Standard requests, complete this form and FAX to 1-877-808-9368. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.

For Expedited requests, please CALL 1-800-218-7508. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Part B Drug requests, complete this form and FAX to 1-844-960-1785.

*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

Primary Procedure Code *

Additional Procedure Code

Start Date OR Admission Date *

Diagnosis Code *

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

Additional Procedure Code

Additional Procedure Code

End Date OR Discharge Date

Total Units/Visits/Days

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

OUTPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes)

712 Cochlear Implants & Surgery	171 Outpatient Surgery
299 Drug Testing	202 Pain Management
922 Experimental and Investigational Services	650 Radiation Therapy
205 Genetic Testing & Counseling	201 Sleep Study
249 Home health	212 Therapy Evaluation
225 Home Meals	790 Occupational Therapy
290 Hyperbaric Oxygen Therapy	101 Physical Therapy
395 Infertility Diagnosis or Treatment	701 Speech Therapy
729 Neuropsychological Testing	993 Transplant Evaluation
410 Observation	209 Transplant Surgery
997 Office Visit/Consult	724 Transportation
794 Outpatient Services	

171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Study
212 Therapy Evaluation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health

510 BH Medical Management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation

DME

417 Rental
120 Purchase (Purchase Price)

422 Biopharmacy (Please fax to 1-844-960-1785)

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 Health Plan Benefit and medically necessary with prior authorization as per Plan 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. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.