OUTPATIENT MEDICAID AUTHORIZATION FORM

Complete and **Fax** to: 1-844-774-2363
Transplant Requests **Fax** to: 1-833-783-0878
Behavioral Health Requests: **FAX** 866-593-1955

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ **Standard requests -** Determination made as expeditiously as the member's health condition requires, but no later than 14 calendar days after receipt of request.

☐ **Urgent requests -** Determination made as expeditiously as the member's health condition requires, but no later than 3 business days after receipt of request.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Medicaid/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* (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) ☐☐☐

Behavioral Health
510 BH Medical Management
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intenstive Outpatient Therapy
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation
530 BH Partial Hospitilization Program
533 BH Applied Behavioral Analysis

412 Auditory Services
712 Cochlear Implants & Surgery
422 Biopharmacy
299 Drug Testing
202 Pain Management
410 Observation
249 Home Health
390 Hospice Services
205 Genetic Testing & Counceling
290 Hyperbaric Oxygen Therapy

201 Sleep Study
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
209 Transplant Surgery
993 Transplant Evaluation
472 Stereotactic Radiosurgery
395 Infertility Diagnosis or Treatment
922 Experimental & Investigational Services

Therapy
101 Physical Therapy
701 Speech Therapy
790 Occupational Therapy

DME
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.

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Supplemental Information Needed for PT/OT/ST Authorization Requests

This document must be submitted with the standard Outpatient Authorization request form.

MEMBER INFORMATION

Member Name _____ Member ID _____ Member Date of Birth _____

REQUIRED DOCUMENTATION CHECKLIST

- ☐ **CURRENT PLAN OF CARE**: Signed and dated specifying frequency, duration and type of treatment.
- ☐ **CURRENT ASSESSMENT**: Must include measurable objectives (ROM/Strength/Pain, etc.), an evaluation that includes standardized functional assessment results for developmental delay requests, if appropriate, and therapist's observations.
- ☐ **CONTINUATION OF CARE REQUESTS**: Documentation of specific progress toward previous goals and updated/current plan of care.
- ☐ **PRESCRIPTION FOR THERAPY**: Must be signed and dated by physician. Outpatient prescriptions are good for 1 year, EPSDT prescriptions are good for 6 months and Home Health prescriptions are good for 60 days unless limited by the referring provider. Verbal orders, for home health requests only, are valid for 30 days from date of issue.

DIAGNOSIS/DISORDER

Primary Diagnosis (ICD-10) _____ Secondary Diagnosis (ICD-10) _____ Treatment Area/Focus _____

THERAPY SERVICE AUTHORIZATION REQUEST FOR TREATMENT

Service location: ☐ Hospital ☐ Outpatient ☐ Clinic/Rehab ☐ Office ☐ Home

Service	Date Treatment Initially Started	Frequency (Visits seen per month or week)	Total Visits or Units	Start Date	End Date
Speech Therapy		____ x ☐ week or ☐ month			
Physical Therapy		____ x ☐ week or ☐ month			
Occupational Therapy		____ x ☐ week or ☐ month			

INITIAL EVALUATION

Discipline: ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

Start date for Initial Evaluation _____

Has the member had an initial evaluation previously this year? ☐ Yes ☐ No

If yes, why is another initial evaluation warranted? _____

RE-EVALUATION

Discipline: ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

Date of Last Evaluation: _____ Authorization Start Date for Re-Evaluation: _____

DISCHARGE PLAN/TRANSITION PLAN

Anticipated discharge date: _____

Plan to transition to home program: _____