



OUTPATIENT MEDICARE AUTHORIZATION FORM

Expedited requests: **Call** 1-855-565-9518
Standard Requests: **Fax** to 1-833-526-7172

Request for additional units. Existing Authorization

Units

For Standard requests, complete this form and FAX to 1-833-526-7172. 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 1-855-565-9518. 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.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID *	Last Name, First	Date of Birth * (MMDDYYYY)
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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	997 Office Visit/Consult
712 Cochlear Implants & Surgery	794 Outpatient Services
299 Drug Testing	171 Outpatient Surgery
922 Experimental Investigational Services	202 Pain Management
799 Genetic Counseling	650 Radiation Therapy
709 Genetic Testing	201 Sleep Study
249 Home Health	790 Occupational Therapy
290 Hyperbaric Oxygen Therapy	101 Physical Therapy
395 Infertility Diagnosis or Treatment	701 Speech Therapy
729 Neuropsych Testing	992 Transplant
410 Observation	724 Transportation
	792 Vendor
	DME (Orthotics and Prosthetics)
	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 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.

