OUTPATIENT MEDICARE AUTHORIZATION FORM

allwell. FROM sunflower health plan.

All Part B Drug Requests **Fax:** 1-844-943-1508
Expedited Requests **Call:** 1-855-565-9519
Standard Requests **Fax**: 1-844-885-3724
Transplant Requests **Fax:** 1-833-590-1589

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

For All Standard or Expedited Part B Drug Requests please FAX to 1-844-943-1508.

For Standard requests, complete this form and FAX to the appropriate department. 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 1-855-565-9519. 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)

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

If this request is for a Part B DRUG, please fax to 1-844-943-1508.

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) ☐☐☐

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental Investigational Services
205 Genetic Testing & Counceling
249 Home Health
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsych Testing
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
422 Biopharmacy (Please fax to 1-844-943-1508)
650 Radiation Therapy
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
212 Therapy Evaluation
790 Occupational Theraoy
101 Physical Therapy
701 Speech Therapy

DME (Orthotics and Prosthetics)

417 Rental
120 Purchase ☐ (Purchase Price)

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 BH Mental Health/Chemical Dependency Observtion
519 BH Outpatient Therapy
520 BH Professional Fees
512 BH Psychological Testing
522 BH Psychiatric Evaluation

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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