OUTPATIENT MEDICAID
PRIOR AUTHORIZATION FAX FORM

Complete and Fax to:
(888) 453-4316

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

☐ Standard Request - Determination within 14 calender days of receiving all necessary information

☐ Urgent Request - I certify this request is urgent to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 72 hours.

X _____

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* ***INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Member ID/Medicaid 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 *

Additional Diagnosis Code (ICD-10)

OUTPATIENT SERVICE TYPE * *(Enter the Service type number in the boxes)* ☐☐☐

712 Cochlear Implants & Surgery
911 Dental Anesthesia - Office Visit

DME
417 Rental
120 Purchase $ (Purchase Price)

299 Drug Testing
709 Genetic Testing
249 Home Health
211 OB Ultrasound(s)

497 Office Visit/Specialty Consult
210 Orthotics $
927 Outpatient Hospice
794 Outpatient Services
411 Surgical Procedures
202 Pain Management
147 Prosthetics $
760 Air Ambulance
771 Dialysis
912 Oxygen Equipment/Gas Supply

If you are requesting Biopharmacy, please use the Biopharmacy Prior Authorization Form on the website.

For high tech imaging, please continue to contact NIA.

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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