

OUTPATIENT AUTHORIZATION FORM

Request for additional units. Existing Authorization Units

Standard requests - Determination within 15 calendar days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

* INDICATES REQUIRED FIELD

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

*Date of Birth

MEMBER INFORMATION

*Member ID Last Name, First (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)

412 Auditory	794 Outpatient Services	Behavioral Health	DME
422 Biopharmacy	171 Outpatient Surgery	510 BH Medical Management	417 Rental
712 Cochlear Implants & Surgery	202 Pain Management	530 BH PHP	120 Purchase (Purchase Price)
299 Drug Testing	650 Radiation Therapy	512 BH Community Based Services	
922 Experimental and Investigational Services	201 Sleep Study	515 BH Electroconvulsive Therapy	
205 Genetic Testing & Counseling	993 Transplant Evaluation	516 BH Intensive Outpatient Therapy	
249 Home Health	209 Transplant Surgery	518 BH Mental Health /Chemical Dependency Observation	
390 Hospice Services	724 Transportation	519 BH Outpatient Therapy	
290 Hyperbaric Oxygen Therapy		520 BH Professional Fees	
395 Infertility Diagnosis or Treatment		521 BH Psychological Testing	
410 Observation		522 BH Psychiatric Evaluation	
997 Office Visit/Consult			

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 benefit and medically necessary with prior authorization as per Ambetter of Illinois policy and procedures.

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