AUTHORIZATION REQUEST

Phone: 1-800-454-3730 Fax: 1-800-964-3627
** To avoid delay, please print clearly **

AMERIGROUP Community Care

TODAY'S DATE: **PROVIDER RETURN FAX #:**

MEMBER INFORMATION (Please verify eligibility prior to rendering service)

NAME: *(Last Name, First Name)* AMERIGROUP #: DOB:

ADDRESS: CITY, STATE, ZIP:

MEDICAID #: OTHER INSURANCE/WORKER'S COMP:

REFERRING PROVIDER INFORMATION

NAME: OFFICE CONTACT NAME:

MEDICAID PROVIDER #: AMERIGROUP #: GROUP PRACTICE #: NPI #:

PHONE #: ❑ Check the box where the OTHER PHONE #: ❑ Fax back

PHONE #: ❑ referral should be faxed back OTHER PHONE #:

SPECIALIST CONSULT

CONSULTANT: *(Last Name, First Name, Provider Specialty)*

AMERIGROUP PROVIDER#: NPI #: PHONE #: FAX #:

ADDRESS: CITY, STATE, ZIP:

ICD-9 CODE/DIAGNOSIS/REASON FOR REFERRAL:

PMH/PREVIOUS STUDIES/TREATMENT:

OF VISITS REQUIRED:

MATERNITY CARE

For initial notification of pregnancy, please use the Maternity Notification form.
For all other services related to pregnancy, please use this form (e.g. ultrasound, fetal non-stress test).

DIAGNOSTIC STUDY

FACILITY NAME: DOS:

DIAGNOSIS/REASON FOR REFERRAL:

PROCEDURE/CPT-4 CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

SURGERY REQUEST

SURGEON'S FULL NAME: *(Last Name, First Name)* DOS: ❑ Inpt ❑ Outpt ❑ Ext Stay

FACILITY NAME:

DIAGNOSIS/REASON FOR SURGERY:

PROCEDURE/CPT-4 CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

OTHER - Clinical Information Needed

❑ DME ❑ Home Health ❑ Hospice ❑ Other

REFERRED TO PROVIDER: *(Last Name, First Name)* AMERIGROUP PROVIDER #: NPI #:

DIAGNOSIS/REASON FOR REFERRAL:

PROCEDURE/CPT-4 CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

** PLEASE ATTACH CLINICAL INFORMATION TO SUPPORT MEDICAL NECESSITY **

This referral is valid only for services authorized by this form. Only completed referrals will be processed. If hte consultant/provider recommends another service or surgery, additional authorization is required. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions, and exclusions.

To be completed by AMERIGROUP: DATE APPROVED:

DATE SPAN: REFERENCE #: INITIALS OF APPROVER: