Magnolia Health Plan

OUTPATIENT
Prior Authorization Fax Form

Fax to: 1-877-650-6943

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

☐ Standard Request - Determination within 2 business days of receiving all necessary information

☐ Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

X ______________________

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

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Date of Birth * (MMDDYYYY)

Member ID/Medicaid ID *

Last Name, First

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-9)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Total Units/Visits/Days

For school-aged Members (Age 3-21) with disabilities/special needs as defined in the Individual with Disabilities Education Act (IDEA):

Is/will the Member be receiving Therapy Services at school? Yes ☐ No ☐

Has Individualized Education Program (IEP) been completed? Yes ☐ No ☐ (If yes, please attach)

OUTPATIENT SERVICE TYPE * *(Fill in the square with an X)*

- ☐ Auditory Services
- ☐ Biopharmacy
- ☐ Cardiac Nuclear Scans
- ☐ Dialysis
- ☐ DME
- ☐ Genetic Testing
- ☐ Home Health

Hospice

- ☐ *Inpatient*
- ☐ *Outpatient*
- ☐ Neuropsychological Testing
- ☐ Nutritional Services
- ☐ Observation

Office Visit / Consult *(Non Par Only)*

- ☐ *Office Visit*
- ☐ *Other Site*
- ☐ Orthotics
- ☐ Outpatient Services
- ☐ Outpatient Surgery
- ☐ Pain Management
- ☐ Sleep Study
- ☐ Prosthetics
- ☐ Sterotactic Radiosurgery

Therapy

- ☐ *Physical Therapy*
- ☐ *Occupational Therapy*
- ☐ *Speech Therapy*
- ☐ Transportation (nonemergent)

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.