Amerigroup RealSolutions in healthcare

KanCare

Precertification request ▪ Phone: 1-800-454-3730 ▪ Fax: 1-800-964-3627

Today's date: **Return fax for prior authorization:**

Please attach clinical information to support medical necessity

Disclaimer: *Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to Amerigroup Kansas, Inc. claims payment policies and procedures*

Member information

Name (Last, first):	Amerigroup ID #:	Date of birth:
Address:	City, State ZIP code:	
State Medicaid ID #:	Other insurance/worker's comp:	

Service/prior authorization request - if requesting durable medical equipment (DME), please include modifier(s), cost and pricing information.

Service type (check all that apply): ❑ DME ❑Occupational therapy ❑ Physical therapy ❑Speech therapy ❑ Home health ❑ Hospice ❑ Pharmacy ❑ Dental surgery ❑ Other (please describe)

Place of service: ❑ Office ❑ Home ❑ Off-campus outpatient ❑ On-campus outpatient ❑ Other

Requested dates of service:

ICD-10 diagnosis code(s):

CPT codes:

Of units/visits and frequency requested:

Servicing provider

Provider name: (Last, First, Provider specialty)	
Amerigroup provider/group ID #:	Office contact name:
Network status: ❑Par ❑Out-of-network (OON)	Phone #:
If OON, will you accept KS Medicaid rates? ❑yes ❑no	Fax #:
Tax ID #:	Address:
NPI #:	City, State ZIP code:
Have you seen this member before? ❑Yes ❑No	

Ordering/referring provider

Provider name: (Last, First)	Office contact name:
Amerigroup provider/group ID #:	Phone #:
Tax ID #:	Fax #:
NPI #:	Address:
Network status: ❑Par ❑OON	

Facility

Facility name:	
Amerigroup provider/facility ID #:	Office contact name:
Network status: ❑Par ❑OON	Phone #:
If OON, will you accept KS Medicaid rates? ❑yes ❑no	Fax #:
Tax ID #:	Address:
NPI #:	City, State ZIP code:
Provider name: (Last, First, Provider specialty)	

Maternity care

For initial notification of pregnancy, please use the Maternity Notification Form found under Maternal Child Program at providers.amerigroup.com.

For all other services related to pregnancy, please use this form (e.g., a second ultrasound, fetal non-stress test).

Surgery request

Surgeon's full name: (Last, First)

Facility (please fill out facility and service information above)

❑ Inpatient ❑ Off-campus outpatient ❑ On-campus outpatient ❑ Extended stay

This referral is valid only for services authorized by this form. Only completed referrals will be processed. If the 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 confirm precertification is required for this service, use the Precertification Lookup tool on the provider self-service website at providers.amerigroup.com. All rentals and out-of-network services require prior authorization when Amerigroup is primary.