ambetter from Superior HealthPlan

OUTPATIENT Prior Authorization Fax Form

Fax to: 855-537-3447

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐ ICD-9 ☐ ICD-10 ☐

☐ Standard Request - Determination within 15 calendar 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 72 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

Member 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)

Start Date *OR* Admission Date ✱ (MMDDYYYY)

Diagnosis Code ✱ (ICD-9)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Total Units/Visits/Days

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

- ☐ Air Ambulance Fixed Wing
- ☐ Biopharmacy
- ☐ Chiropractic
- ☐ Cochlear Implants and Surgery
- ☐ DME
- ☐ Enteral Feedings
- ☐ Genetic Testing
- ☐ Home Health
- ☐ Hospice Outpatient
- ☐ Observation Stay
- ☐ OB Ultrasound
- Office Visit
  - ☐ Office Visit
  - ☐ Other Site
- ☐ Orthotics
- ☐ Outpatient Services
- ☐ Pain Management
- ☐ Parenteral Feedings
- ☐ Prosthetics
- ☐ Quantitative Urine Drug Screen
- Sleep Study
  - ☐ Home
  - ☐ Other Site
- ☐ Surgical Procedures

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.